

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11120

CERTIFICATE OF DEATH

11121

1. PLACE OF DEATH a. COUNTY <u>Montt.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>17 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS Hosp.</u>				d. STREET ADDRESS <u>4100 Highview Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARTINO ACQUAVIVA</u>				DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-14</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>31</u> Days <u>19</u> Hours <u>67</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barbering</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Nito A. Acquaviva</u>				14. MOTHER'S MAIDEN NAME <u>Teresa Curci</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-50-9084</u>		17. INFORMANT <u>Mrs. Anna Acquaviva</u> Address <u>Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO (b) <u>1621</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>last</u> DUE TO (c) <u>last</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 1967, to <u>8/31</u> , 1967, that (I) (we) last saw the deceased alive on <u>8/31</u> , 1967, and that death occurred at <u>8 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>G. Lennard Gold</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>				22d. ADDRESS <u>8641 Colesville Rd. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>SEP 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

STATE OF CALIFORNIA

1911

11121

CERTIFICATE OF DEATH

11222

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY Washington, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 27 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d. STREET ADDRESS 3816 17th Place, N.E.	
3. NAME OF DECEASED (Type or print) Melvin Leroy Ailer, Jr.		First Middle Last		4. DATE OF DEATH Month Day Year August 11 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 April 1936		9. AGE (In years lost birthday) yrs. 31
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
13. FATHER'S NAME Melvin L. Ailer, Sr.			14. MOTHER'S MAIDEN NAME Edna Fray		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1959		16. SOCIAL SECURITY NO 579-46-5247		17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Acute renal failure, etiology unknown DUE TO (c) Acute Lymphocytic Leukemia					INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from 15 July , 19 67 , to 11 August , 19 67 , that (X) (we) lost saw the deceased alive on 11 August 19 67 , and that death occurred at 4:20 P.M. from causes and on the date stated above					
22a. SIGNATURE Joseph D. Croft, Jr.			22b. DATE SIGNED 12 August 1967		
22c. PHYSICIAN'S NAME (Type) Joseph D. Croft, Jr., MD			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/15/67	23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM. CEM.	23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND		
24. FUNERAL DIRECTOR Robert L. L. L.		25a. REC'D BY REGISTRAR DATE AUG 15 1967	25b. REGISTRAR'S SIGNATURE Charles Judge		

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VR A15 (4)
25M 1/67

1912

THE STATE OF TEXAS

County of _____

State of _____

Know all men by these presents, _____

of the County of _____

State of _____

do hereby certify that _____

is the true and correct copy of the _____

and the same is a true and correct copy of the _____

A _____

WITNESSED my hand and seal this _____ day of _____

1912.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

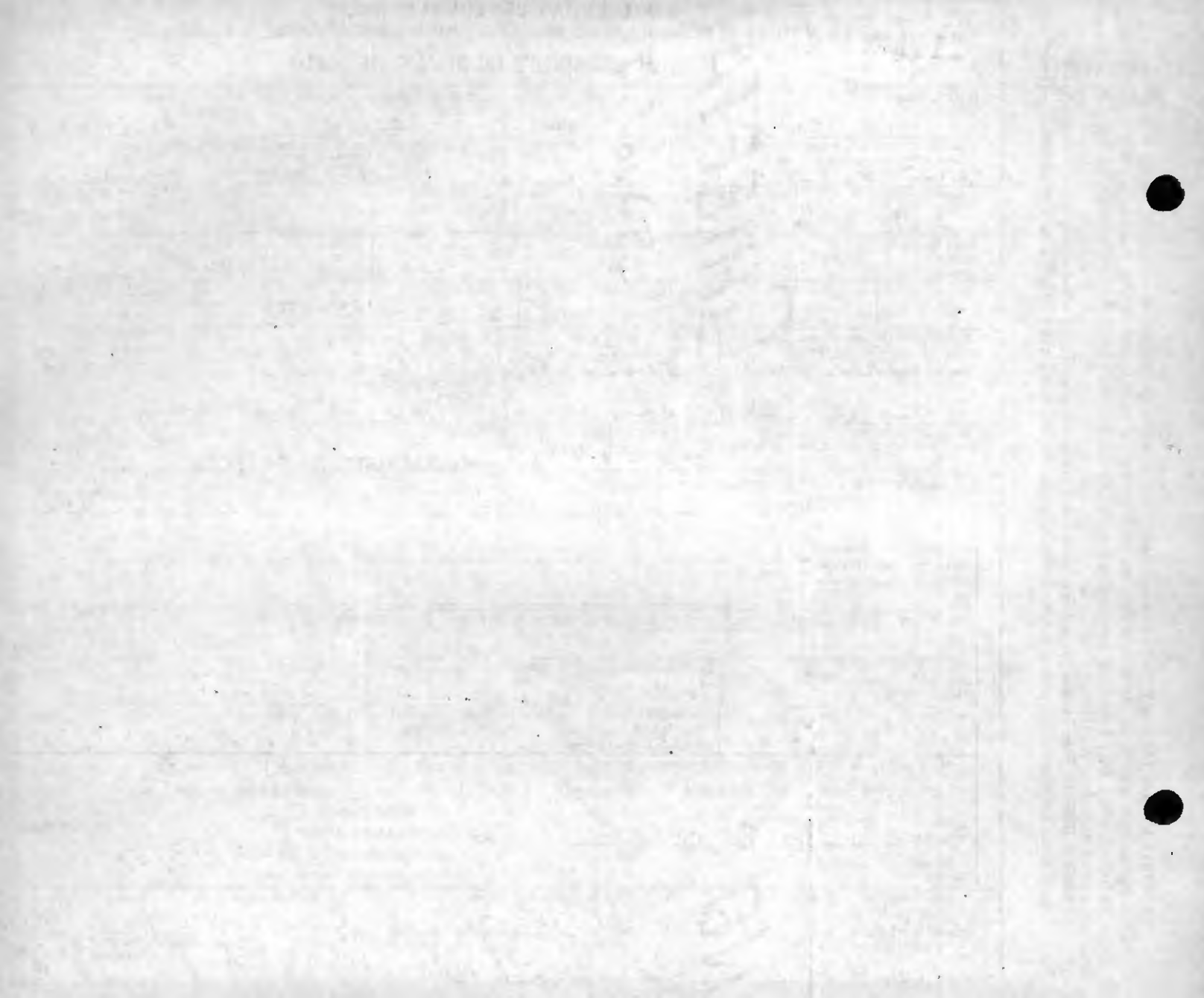
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Poolesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Istac-Walton League</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>James H. Anderson</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20 - 1937</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Supply</u>	9. AGE (In years last birthday) <u>30</u> yrs.
13. FATHER'S NAME <u>James Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Mae Whisman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-34-703</u>	
17. INFORMANT <u>Mrs. Lois Anderson</u>		Address <u>Poolesville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Head</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Traffic Plo. Crushed head against auto.</u>	
20c. TIME OF INJURY Month, Day, Year <u>9:20 a.m. 8/13 1967</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>	20f. (City or town) (County) (State) <u>Poolesville Mont. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John H. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/15/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		23d. LOCATION (City or town) (County) (State) <u>Barnesville Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>William B. Hillen Barnesville Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 16 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



11123

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>12hrs 5min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General</u>			d. STREET ADDRESS <u>Rt. #2 Box 31</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Jack</u> Last <u>Arnold</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>13</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-92</u>	9. AGE (In years - lost birthday) yrs. <u>74</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u> Hours <u>15</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Live stock dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Live stock</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Charles Arnold</u>		
14. MOTHER'S MAIDEN NAME <u>Emma Jefferson</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u>		
16. SOCIAL SECURITY NO. <u>220-09-5284</u>			17. INFORMANT <u>Mrs. Andrew J. Arnold</u> Address <u>Same as #2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Cancer of Lung.</u> <u>163X</u> DUE TO <u>Effusion.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8-12</u> , 19 <u>67</u> , to <u>8-13</u> , 1967, that (I) (we) last saw the deceased alive on <u>8-13</u> , 19 <u>67</u> , and that death occurred at <u>2A</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>M. McKendree Boyer</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>8/13/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>M. McKendree Boyer, M.D.</u>		22d. ADDRESS <u>9701 Church St. Gaithersburg, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-15-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg, Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber</u> <u>Laytonville, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>AUG 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John Judge</u>

STATE OF NEW YORK

Five stock shares

NY

Serial 1-1-07 Forest Gap

Frank J. Baker, New York, N.Y.

Delivered, New York, N.Y.

100 1/2 Bbl

11124

CERTIFICATE OF DEATH

11125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in lb <u>1 month</u>		d. STREET ADDRESS <u>1404 1220 Blair Mill Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis Anthony Bagatti</u>		4. DATE OF DEATH <u>August 15 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deceased Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Bagatti</u>		14. MOTHER'S MAIDEN NAME <u>Maria Serventi</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-5742</u>	
17. INFORMANT <u>Sue Ann Bagatti</u> Address <u>1220 Blair Mill Road</u>		18. RECORD <u>Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach - metastases</u>			
DUE TO (b) _____			
DUE TO (c) _____			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-15-67</u> to <u>8-15-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-15-67</u> 19 <u>67</u> , and that death occurred at <u>10:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>James L. Whitlock, M.D.</u>		22b. DATE SIGNED <u>8-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James Whitlock, M. D.</u>		22d. ADDRESS <u>7717 Carroll Ave Takoma Park, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>Aug 19, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

THE UNIVERSITY OF CHICAGO

1911
JAN 17 1911

RECEIVED

THE UNIVERSITY OF CHICAGO
LIBRARY

1911

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO
LIBRARY
JAN 17 1911

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Items 18-21 Film 392</div> <div>19-19-67 ams</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>11125</div> <div>11126</div>											
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>16</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hospital</u>						d. STREET ADDRESS <u>1415 Jefferson St.</u>					
3 NAME OF DECEASED (Type or print) <u>Michael John Balamoti</u>						4 DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12 Nov. 1894</u>		9. AGE (In years last b. rthday) <u>72</u> yrs		11. BIRTHPLACE (State or foreign country) <u>Greece</u>	
10a. USUAL OCC. PAT ON (Give kind of work done during most of working life, even if retired) <u>Retired - waiter WASHINGTON HOTEL</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON HOTEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>John M. Balamoti</u>						14. MOTHER'S MAIDEN NAME <u>ADELPHI MD.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>577-01-8528</u>		17. INFORMANT <u>SON JOHNNY M. BALAMOTI</u>				Address <u>10434 EDGEFIELD</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure due to</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration of gastric contents</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19. WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Deceased vomited and aspirated gastric contents.</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>6:00PM</u> p.m. <u>8/17/67</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u>Home</u>		20f. (City or town) (County) (State) <u>Hyattsville Pr. Geo. Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u>				EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>				22. DATE SIGNED <u>8/17/1967</u>			
23a. BURIAL, CREMATION, or OTHER DISPOSAL <u>SERIAL</u>				23b. DATE THEREOF <u>21 AUG. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>				23d. LOCATION (City or town) (County) (State) <u>ADAMS MARYLAND</u>	
24. FUNERAL DIRECTOR <u>FINLEY FUNERAL HOME 7460 GEORGIA AVE. NW</u>						ADDRESS <u>POC 2-016</u>		25a. REC'D BY REG STRAR <u>DATE AUG 21 1967</u>		25b. REG STRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Echo Heights c. LENGTH OF STAY IN 1b years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5445 Mohican Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Echo Heights d. STREET ADDRESS 5445 Mohican Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First EBB Middle C. Last BARRINGTON			4. DATE OF DEATH Aug. 11, 1967 Month Aug. Day 11 Year 1967						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 26, 1892		9. AGE (in years last birthday) 75 yrs. IF UNDER 1 YEAR: Months 7 Days 15 Hours 15 Min. IF UNDER 24 HRS. 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Claim Examiner			10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt			11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ebb Barrington					14. MOTHER'S MAIDEN NAME Martha Britt				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes. WW I			16. SOCIAL SECURITY NO. 577-34-2344		17. INFORMANT Wife Address Same as Item 2.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Arteriosclerotic heart disease DUE TO (c) with coronary sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Herpes zoster		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept 6, 1967 to Aug 11, 1967 , that (I) (we) last saw the deceased alive on Aug 11, 1967 , and that death occurred at 11:45 PM from the causes and on the date stated above.									
22a. SIGNATURE C. P. Ryland					22b. DATE SIGNED 8-12-67				
22c. PHYSICIAN'S NAME (Type) C. P. RYLAND					22d. ADDRESS 1400-49th St NW Wash DC 20016				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8-15-67		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR AUG 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11127

11128

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN b. 15 days/12 hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium Hospital		e. STREET ADDRESS 12216 Conn. Ave.	
3. NAME OF DECEASED (Type or print) GOLDIE OLIVIA BEALL		4. DATE OF DEATH Month August Day 29 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1902
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 2 Days 29 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) h.s.w.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Fields		14. MOTHER'S MAIDEN NAME Betty Evelyn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 577-22-0943	
17. INFORMANT Hospital Records		Address 7600 Carroll Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute monocytic leukemia DUE TO (b) 4 d Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 19 days DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Pneumonitis, anemia, granulocytopenia, thrombocytopenia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/13, 1967 to 8/29, 1967 , that (I) (we) last saw the deceased alive on 8/29, 1967 , and that death occurred at 5:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Donald W. Datlow		22b. DATE SIGNED 8-29-67	
22c. PHYSICIAN'S NAME (Type) DONALD W. DATLOW		22d. ADDRESS 823 University Blvd. W. Silver Spring, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-31-67	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR AUG 31 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11128

11129

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>7-30-66-1 yr</u> <u>9-10-67 1 day</u>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Simpsonville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Convalescent Home</u>		d. STREET ADDRESS <u>217 Groveleigh Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lauretta</u>		First Middle Last <u>Bea H</u>		4. DATE OF DEATH <u>August 10, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/11/1879</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Patrick Martin</u>		14. MOTHER'S MAIDEN NAME <u>Henny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Eugene Alber</u> Address <u>217 Groveleigh Drive Simpsonville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary occlusion</u> DUE TO (b) <u>hypertensive cardiac vascular disease</u> DUE TO (c) <u>arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>20 + yrs</u> <u>20 + yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1944</u> to <u>Aug 10, 1967</u> , that (I) <u>was</u> last saw the deceased alive on <u>June 6, 1967</u> and that death occurred at <u>5:30</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>James E. Nolan</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>Aug 10-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>James E. Nolan, M.D.</u>		22d. ADDRESS <u>5401 Western Ave NW Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Herndon, Virginia</u>		
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> Address <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>AUG 17 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

Dr. Fern notified and appeared

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11128

21130

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN b. <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9209 Sazbrook Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9209 Sazbrook Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILBUR THOMAS BEALL</u> First Middle Last f. SEX <u>Male</u> g. COLOR OR RACE <u>White</u> h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> i. DATE OF BIRTH <u>May 8 1911</u> j. AGE (in years last birthday) <u>56</u> yr. k. IF UNDER 1 YEAR Months Days l. IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>August 3, 1967</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Silver Spring Post Office</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Wash. DC</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas N. Beall</u> 14. MOTHER'S MAIDEN NAME <u>Charlotte Schultze</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <u>218-24-0372</u> 17. INFORMANT <u>Dorothy M Beall</u> Address <u>9209 Sazbrook Ave Silver Spring Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pharynx with</u> Conditions, if any, which gave rise to immediate cause (b) <u>metastasis</u> (c), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>3 Aug 1967</u> , that (I) (we) last saw the deceased alive on <u>1 Aug 1967</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>William D And</u> M.D.		22b. DATE SIGNED <u>8/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D And MD</u>		22d. ADDRESS <u>4406 Colesville Rd. Silver Spring Md</u>	
23b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23c. DATE THEREOF <u>8/7/67</u>	23d. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23e. LOCATION (City, town or county) <u>Silver Spring Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers, Inc.</u> ADDRESS <u>Silver Spring Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>AUG 7 1967</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11130

11131

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>NEW JERSEY</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DETHLESDA</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>28 NORTH CLERMONT AVE</u>	
3 NAME OF DECEASED (Type or print) First <u>ADOLPH</u> Middle Last <u>BECKER SR</u>		4 DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-8-88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Business</u>		9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Franz Becker</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Schoenberg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>150 09 3136</u>	
17. INFORMANT <u>Walter E. Becker - son - Kensington, Md.</u>		Address <u>5311 Flanders Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Nephrosclerosis and pyo-ureters, bilateral</u> DUE TO (c) <u>Adenocarcinoma, prostate gland</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-3</u> , 19 <u>67</u> , to <u>8-1</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7-31</u> 19 <u>67</u> , and that death occurred at <u>12</u> AM, from causes and on the date stated above			
22a. SIGNATURE <u>John D. Maylath</u>		22b. DATESIGNED <u>8/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John D. Maylath</u>		22d. ADDRESS <u>50 W. Edmonston Drive, Rockville, Md.</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>New Jersey</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25a. ADDRESS <u>1321 Rockville Pike Rockville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11131

Item #9 Film #5352 8/2/67

CERTIFICATE OF DEATH

11132

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 13 Mos.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ALTHEA WOODLAND Nursing Home				d. STREET ADDRESS 6919 Strathmore Street			
3. NAME OF DECEASED (Type or print) MARION First HOEFFEL BENTLEY Middle Y Last				4. DATE OF DEATH AUGUST 23 1967 Month AUGUST Day 23 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-27-1888	9. AGE (in years last birthday) 78 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Conoto Wisc.	
13. FATHER'S NAME I.S.P. HOEFFEL				14. MOTHER'S MAIDEN NAME GENIEVE HEOTH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 016-22-085		17. INFORMANT Son Address 18 Wilton Rd. W. Ridgefield, Conn.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pulmonary Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease; Emphysema							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March, 1967 to Aug, 1967 , that (I) (we) last saw the deceased alive on Aug 22 1967 , and that death occurred at 5:47 M. from the causes and on the date stated above.							
22a. SIGNATURE Bernard A Fitzgerald				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-23-67	
22c. PHYSICIAN'S NAME (Type) BERNARD A FITZGERALD				22d. ADDRESS 17 UNIV BLVD E. S.L. SPRING, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-25-67		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR AUG 28 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared & Med Exam

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11133											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, Md.</u>						c. LENGTH OF STAY IN 1b <u>17 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS Hospital</u>						d. STREET ADDRESS <u>11354 Cherryhill Road</u>					
3. NAME OF DECEASED (Type or print) First <u>ADAM</u> Middle <u>E.</u> Last <u>BERGER</u>						4. DATE OF DEATH Month <u>Aug.</u> Day <u>1</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/15/67</u>		9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BABY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (County & State, or foreign country) <u>HOLY CROSS HOSPITAL SILVER SPRING, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ALAN L. BERGER</u>						14. MOTHER'S MAIDEN NAME <u>KAREN MEANY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>PR. CHART</u>			Address <u> </u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal hydrocephalus</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status post cerebral ventriculotomy, recent</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-27</u> , 19 <u>67</u> to <u>8-1</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8-1</u> , 19 <u>67</u> and that death occurred at <u>8:00</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Jonathan M. Williams</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>8-2-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Jonathan M. Williams</u>						22d. ADDRESS <u>808 Pershing Dr. Silver Spr</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-4-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Natl. Mem. Park</u>			23d. LOCATION (City, town or county) (State) <u>Balls Bluff Church Virginia</u>				
24. FUNERAL DIRECTOR <u>Holberg Funeral Home</u>						ADDRESS <u>4217 N. W. D. C.</u>		25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
						DATE <u>AUG 7 1967</u>					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11133

CERTIFICATE OF DEATH

21134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN Tb 3 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Univ. Nursing Home Wheaton, Md.		a. STREET ADDRESS 14106 Bauer Dr.	
3. NAME OF DECEASED (Type or print) First Nellie Middle Blanche Last Bittinger		4. DATE OF DEATH Month August Day 17 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/1890
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 17 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (County & State or foreign country) Swanton, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Francis Pritts	
14. MOTHER'S MAIDEN NAME Harriet Scooley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None	
16. SOCIAL SECURITY NO 178-05-7452		17. INFORMANT Mrs. Verna Lindsay	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 272		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May , 1967, to 8-17 , 1967, that (I) (we) last saw the deceased alive on 8-17 , 1967, and that death occurred at 8:35 M, from causes and on the date stated above.			
22a. SIGNATURE D. L. Bucky		22b. DATE SIGNED 8-18-67	
22c. PHYSICIAN'S NAME (Type) D. L. Bucky		22d. ADDRESS 809 Van's Mill Rd Rockville Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial	23b. DATE THEREOF Aug 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Lafayette Memorial Cemetery	23d. LOCATION (City or Town) (County) (State) Brier Hill, Pennsylvania
24. FUNERAL DIRECTOR Glen Carter Collins		25a. REC'D BY REGISTRAR 4434 Georgia Avenue Silver Spring, Md.	25b. REGISTRAR'S SIGNATURE Charles Judge

11134

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11135

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Holy Cross Hospital</u>		e. STREET ADDRESS <u>929 Northampton Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Marie C. Blackstone</u>		4. DATE OF DEATH <u>Aug. 30 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1908</u> 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert H. Cook</u>		14. MOTHER'S MAIDEN NAME <u>Minnie C. Speir</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Richard D. Blackstone</u>		Address <u>929 Northampton Dr. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema.</u> DUE TO (b) <u>Massive Pleural Effusion.</u> DUE TO (c) <u>Metastasis Carcinoma of breast.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u> <u>30 days.</u> <u>3 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nor While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1965</u> to <u>8-30-1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>8-27-1967</u> , and that death occurred at <u>2:05</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Morton Altschuler</u>		22b. DATE SIGNED <u>8-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morton Altschuler, MD.</u>		22d. ADDRESS <u>9205 New Hays Ave. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Sept. 1, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>All Saints Episc. Church</u>	23d. LOCATION (City or town) (County) (State) <u>Oakley, Maryland</u>
24. FUNERAL DIRECTOR <u>Harner E. Humphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11135

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Bethesda,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4890 Battery Lane		d. STREET ADDRESS 4890 Battery Lane	
3 NAME OF DECEASED (Type or print) ELIZABETH BONHAG		4 DATE OF DEATH Month Aug. Day 10 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1908
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Franklin C. Getzendanner		14. MOTHER'S MAIDEN NAME Elizabeth Moffatt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-18-8176	
17. INFORMANT Husband		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO Myocardial infarction (b) Arterio-sclerotic heart disease DUE TO Arterio-sclerotic heart disease (c) Arterio-sclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1966 to 8/4, 1967 that (I) (we) last saw the deceased alive on 8/4, 1967 , and that death occurred at 8:00 A. M. from causes and on the date stated above.			
22a. SIGNATURE William L. Howell		22b. DATE SIGNED 8/11/67	
22c. PHYSICIAN'S NAME (Type) WILLIAM L. HOWELL		22d. ADDRESS Washington, D.C. 5401 Western Ave. N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-14-67	23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE AUG 21 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11136

11137

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>Do 9</u>				2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admitt on) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sant Hospital</u>				d. STREET ADDRESS <u>746 Thayer Ave.</u>			
3 NAME OF DECEASED (Type or print) <u>Mary C. Borgman</u>				4 DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-28-06</u>	9 AGE (In years last birthday) yrs. <u>61</u>	10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	11 IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11 BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick H. Cuff</u>				14. MOTHER'S MAIDEN NAME <u>Delphia</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>46 Thayer Avenue</u> Address <u>Eugene S. Borgman</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease.</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS A. TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>8/17/1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Suburban, town or county) <u></u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>Aug 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ambrose Cemetery</u>	23d. LOCATION (City or Town) <u>Cresaptown, Maryland</u>	(County)	(State)		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey Inc. 8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>Charles J. Jones</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

CERTIFICATE OF DEATH

11138

11137

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY IN 1b <u>10 mo 9 da.</u>		d. STREET ADDRESS <u>3741 military Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>HARRIET G. Bowling</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25 1883</u>
9. AGE (in years lost birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Office Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt-retired</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>ALABAMA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JASON G Gillette</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH HAND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>423-42-1182</u>	
17. INFORMANT <u>Daughter Elizabeth B. Adams</u>		<u>3928 McKinley St. Washington, D. C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>1001</u> IMMEDIATE CAUSE (a) <u>Cerebral congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>diocese</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>57 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>a.m.</u> Month <u>19</u> Day <u>19</u> Year <u>1967</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1966</u> to <u>Aug 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug. 25 1967</u> , and that death occurred at <u>6 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John E. Morris</u>		22b. DATE SIGNED <u>8/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. MORRIS</u>		22d. ADDRESS <u>1746 K Street, N. W. Washington, D. C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.



CERTIFICATE OF DEATH

11109

11133

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 77 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Connecticut b. COUNTY East Haven	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harrison Horton Boyd, Jr.		4. DATE OF DEATH Month August Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 July 1948
9. AGE (In years last birthday) 19 yrs		10. IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harrison H. Boyd, Sr.		14. MOTHER'S MAIDEN NAME Phyllis Bishop	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Maryland 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple hemorrhages, subdural, gastrointestinal DUE TO (b) Aplastic Anemia, idiopathic DUE TO (c) myocardial Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2 7 1 4		INTERVAL BETWEEN ONSET AND DEATH 2 hours 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5 June , 19 67 , to 21 August , 1967, that (I) (we) last saw the deceased alive on August 21 , 19 67 , and that death occurred at 8:15 M. from causes and on the date stated above.			
22a. SIGNATURE <i>David L. Lilien</i>		22b. DATE SIGNED 22 August 1967	
22c. PHYSICIAN'S NAME (Type) David L. Lilien, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014	
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial	23b. DATE THEREOF 8/25/67	23c. NAME OF CEMETERY OR CREMATORY Beaver Dale Mem. Pk.	23d. LOCATION (City or Town) (County) (State) New Haven, Conn.
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Md.	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE AUG 25 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
11138										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1203 Ballard Street</u>					d. STREET ADDRESS <u>1203 Ballard Street</u>					
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>M</u> Last <u>BRACEY</u>					4. DATE OF DEATH Month <u>AUGUST</u> Day <u>30</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 11, 1876</u>		9. AGE (In years last birthday) <u>91</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles L. Burch</u>					14. MOTHER'S MAIDEN NAME <u>Maria Turner</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Marguerite T. Brown</u> Address <u>1203 Ballard St. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE.</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>AUGUST, 1960</u> , to <u>AUG. 20, 1967</u> , that (1) (we) last saw the deceased alive on <u>AUG. 28, 1967</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>James R. Coleman MD.</u>					22b. DATE SIGNED <u>8/30/67</u>		22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>			
22d. ADDRESS <u>9241 COLUMBIA BLVD</u>					22e. <u>SILVER SPRING, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sept. 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>			
24. FUNERAL DIRECTOR <u>Arner (John) B. Thomas</u>					25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 1-141

1. **PLACE OF DEATH**
 a. COUNTY MONTGOMERY MARYLAND
 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
 c. LENGTH OF STAY IN 1b
 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8105 EASTERN AVE.

2. **USUAL RESIDENCE** (Where deceased lived, if institution; Residence before admission)
 a. STATE MARYLAND b. COUNTY MONTGOMERY
 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
 d. STREET ADDRESS 8105 EASTERN AVE. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print) First Middle Last
EVA BRELOW
 4. **DATE OF DEATH** Month Day Year
AUG. 4 19 67

5. **SEX** Female 6. **COLOR OR RACE** White 7. **MARRIED** ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
 8. **DATE OF BIRTH** Aug 30-1897 9. **AGE** (In years last birthday) 69 10. **IF UNDER 1 YEAR** Months Days 11. **IF UNDER 24 HRS.** Hours Min.

10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. **KIND OF BUSINESS OR INDUSTRY** - 11. **BIRTHPLACE** (County & State, or foreign country) POLAND 12. **CITIZEN OF WHAT COUNTRY?** U.S.A.

13. **FATHER'S NAME** ISRAEL ZWEIG 14. **MOTHER'S MAIDEN NAME** REBECCA

15. **WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) No 16. **SOCIAL SECURITY NO.** UNKNOWN 17. **INFORMANT** Robert Koselbaum Address 14400 BAYVIEW DR. ROCKVILLE, MD.

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) ACUTE LEFT VENTRICULAR FAILURE
 DUE TO (b) CORONARY ARTERIOSCLEROTIC HEART DISEASE
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)
 19. **WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. **ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** (If either, NOTIFY MEDICAL EXAMINER) ☐ No 20b. **DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)
 20c. **TIME OF INJURY** Month, Day, Year Hour a.m. p.m. 19 20d. **INJURY OCCURRED** While at work ☐ Not While at work ☐ 20e. **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) 20f. **(City or town)** (County) (State)

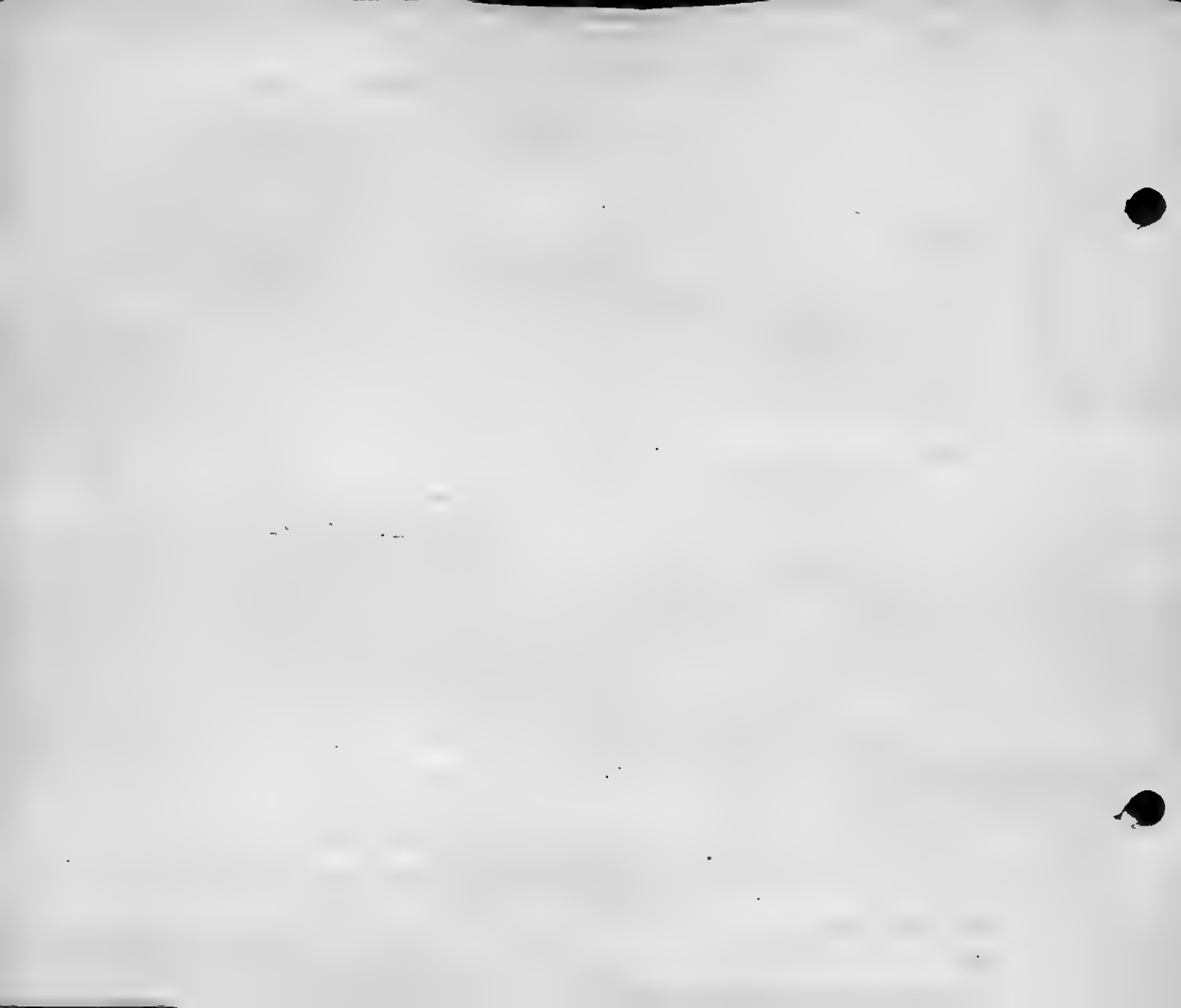
21. **I certify that (I) (this hospital) attended the deceased from** APRIL 7, 1964 **to** AUG. 4, 1967, that (I) (we) last saw the deceased alive on AUG. 4, 1967, and that death occurred at 4 A.M. from the causes and on the date stated above.

22a. **SIGNATURE** Israel Kessler M.D. **ATTENDING PHYS.** ☒ **MED. DIRECTOR** ☐ **STAFF PHYS.** ☐ 22b. **DATE SIGNED** 8/4/67
 22c. **PHYSICIAN'S NAME (Type)** ISRAEL KESSLER M.D. 22d. **ADDRESS** 5801-16 ST. NW. WASH., D.C.

23a. **BURIAL, CREMATION, OR REMOVAL (Specify)** BURIAL 23b. **DATE THEREOF** 8/6/67 23c. **NAME OF CEMETERY OR CREMATORY** S.E. HEBREW CON. CEM. 23d. **LOCATION (City, town or county)** (State) WASH., D.C.

24. **FUNERAL DIRECTOR'S SIGNATURE** Goldberg Funeral Home ADDRESS 4217-9th Ave 25a. **REC'D BY REGISTRAR** AUG 7 1967 25b. **REGISTRAR'S SIGNATURE** Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
c. LENGTH OF STAY IN TOWN <u>10 yrs</u>		d. STREET ADDRESS <u>2808 Abilene Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>2808 Abilene Drive</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Joseph N. M. N. Brenner</u>		4 DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec 9 1917</u>
9 AGE (In years last birthday) <u>49</u> yrs		10 IF UNDER 1 YEAR Months <u>49</u> Days <u>49</u> Hours <u>49</u> Min <u>49</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Store.</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Samuel Brenner</u>	
14 MOTHER'S MAIDEN NAME <u>Rose Levine</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO.		17 INFORMANT Address <u>2808 Abilene</u> <u>wife-Cecilia Brenner Ck. Ch. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>4201</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>8/30/67</u>		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town or county)			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-31-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN FALLS CHURCH, VA.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS - WASHINGTON, DC</u>		25a. REC'D BY REGISTRAR <u>AUG 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



CERTIFICATE OF DEATH

11142

11143

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c LENGTH OF STAY IN 1b <u>2 mos</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8704 Milford Ave</u>		d STREET ADDRESS <u>Silver Spring,</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL HALL Nur. Home</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>BEATRICE D. BRECKEY</u>		4 DATE OF DEATH <u>Aug 12 19 67</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-3-1887</u>
9 AGE (In years last birthday) <u>79</u> yrs		10 IF UNDER 1 YEAR <u>19 67</u> Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY</u>		10b KIND OF BUSINESS OR INDUSTRY <u>- -</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>William C. Daw</u>		14 MOTHER'S MAIDEN NAME <u>Lillian Cluss</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>579-28-7222</u>	
17 INFORMANT <u>Mr. W.S. Shacklette</u>		Address <u>Silver Spring, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Debility and Exhaustion</u> 331X DUE TO (b) <u>Perforated Vomer, Pericardial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Perforated Sclerotic (Pericardial and aortic)</u>			INTERVA. BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Numerous. Debility and Exhaustion</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/3/66</u> to <u>8/12/67</u> , that (I) (we) lost the deceased alive on <u>8/12/67</u> , and that death occurred at <u>12/3/67</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>William F. Argyrakis</u>		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>William F. Argyrakis</u>		22d. ADDRESS <u>5201 Conn Ave - N.W. D.C.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>Aug 14, 1967</u>	<u>OAK Hill Cem.</u>	<u>Washington, D.C.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler's Son's Inc. Wash, D.C.</u>		25a RECD BY REGISTRAR <u>AUG 17 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>29 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1007 Crest Park Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ellie Eran Brown</u>		4. DATE OF DEATH Month Day Year <u>Aug. 29 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/85</u>
9. AGE (In years, lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Andrew Jackson Williams</u>	
14. MOTHER'S MAIDEN NAME <u>Maggie Fulton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes give war or dates of service	
16. SOCIAL SECURITY NO		17. INFORMANT <u>Washington San. & Hosp. Records</u> Address <u>Takoma Park, Md</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary artery disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Unknown</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1, 1967</u> to <u>Aug. 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug. 29, 1967</u> , and that death occurred at <u>5:47 M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Albert H. Grollman</u>		22b. DATE SIGNED <u>8/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 1, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Colman Manor Pk. H. Md.</u>
24. FUNERAL DIRECTOR <u>Takoma Funeral Home 254 Carroll St NW</u>		25a. REC'D BY REGISTRAR <u>SEP 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CERTIFICATE OF DEATH

11145

11144

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MONTGOMERY GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>3711 Norbeck Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph Nathan Browning</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-06</u>
9. AGE (In years last birthday) <u>61 yrs</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Browning</u>		14. MOTHER'S MAIDEN NAME <u>Cammie Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL MASSIVE HEMORRHAGE</u>			
DUE TO (b) <u>BLEEDING ESOPHOGEAL VARICES</u>			
DUE TO (c) <u>CIRRHOSIS LAENEC'S LIVER</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>5 YRS +</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>0</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>67</u> to <u>8/20</u> , 19 <u>67</u> that (1) (we) lost saw the deceased alive on <u>8/20</u> , 19 <u>67</u> , and that death occurred at <u>6:15 PM</u> from causes and on the date stated above			
22a. SIGNATURE <u>Donald R. Lewis</u>		22b. DATE SIGNED <u>8/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Donald Lewis</u>		22d. ADDRESS <u>OLNEY, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-25-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>		23d. LOCATION (City or Town) (County) (State) <u>Lndover, Md.</u>	
24. FUNERAL DIRECTOR <u>Fraziers</u>		ADDRESS <u>Washington, D.C.</u>	
25a. REG. DR. REG. REGISTRAR DATE <u>AUG 28 1967</u>		25b. REG. DR. REG. REGISTRAR DATE <u>John R. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

11145

1-146

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Cuyahoga Falls</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>36 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cuyahoga Falls</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014 The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>1340 Hillcrest Drive, Apt. 104</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Suzanne</u> Middle <u>Marie</u> Last <u>Brueggeman</u>				4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 March 1946</u>		9. AGE (In years last birthday) <u>21</u> yrs		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert E. Brueggeman</u>				14. MOTHER'S MAIDEN NAME <u>Ernestine Nance</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>282-42-9517</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland 20014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia. (Bilateral)</u> DUE TO <u>to Lupus Nephritis</u> (b) <u>Systemic Lupus, Erythematosis, with Uremia, due/</u> DUE TO <u>2 Months</u> (c) <u>2 Years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>0</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 27</u> , 19 <u>67</u> , to <u>August 2</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 2</u> , 19 <u>67</u> , and that death occurred at <u>7:00 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Henry B. Kaltreider</u>				22b. DATE SIGNED <u>2 August 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Henry B. Kaltreider, MD.</u>	
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Northlawn Memorial Pk.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cuyahoga Falls, Ohio</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons 5130 Wisc. Ave NW</u>				25a. REC'D BY REGISTRAR <u>Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

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MONTGOMERY COUNTY, MARYLAND											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>P. Geo.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN <u>10</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>						d. STREET ADDRESS <u>102 Woodland Ct #102</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marte</u> Middle <u>Johnella</u> Last <u>Bruton</u>						4. DATE OF DEATH Month <u>Aug</u> Day <u>17</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 9 1901</u>		9. AGE (In years, lost birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. US. JAV. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Toledo Ohio</u>				12. CIT. ZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Miller</u>						14. MOTHER'S MAIDEN NAME <u>Maudie Wensmore</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Thomas McBride - Rhine</u> Address <u>- Rhine</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Right & left ventricular cardiac failure, with hypertrophic and right ventricular dilatation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral bullous pulmonary emphysema</u> (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>(terminal) bilateral bronchopneumonia</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.											
22a. SIGNATURE <u>Richard Compton</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>J. RICHARD COMPTON</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Brutonville Md.</u>			
24. FUNERAL DIRECTOR <u>De Witt Sarnedman</u>						ADDRESS <u>Laurel, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 22 1967</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1114

11148

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 20 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 270 Bearded Oaks Drive	
3 NAME OF DECEASED (Type or print) First Edward Middle Joseph Last BURKE		4 DATE OF DEATH Month 8 Day 18 Year 1967	
5. SEX Male	6 COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 November 1907
9. AGE (in years last birthday) 59 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Military		10b. KIND OF BUSINESS OR INDUSTRY USN	
11. BIRTHPLACE (County & State, or foreign country) Larksville, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Edward Joseph Burke		14. MOTHER'S MAIDEN NAME Briget Connor	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes 1929 to 1959		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Adele F. Burke		Address Chevy Chase Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cirrhosis, liver DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 30 July 1967 to 18 August 1967 , that (I) (we) last saw the deceased alive on 18 August 1967 , and that death occurred at 10:15 A.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>John C. Mullen for</i>		22b. DATE SIGNED 18 Aug 1967	
22c. PHYSICIAN'S NAME (Type) J.B. EMERY		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-22-67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR R.A. Pumphrey, 7557 Wisconsin Ave, Bethesda Md.		25a. REC'D BY REGISTRAR DATE AUG 23 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	



CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>422 Pershing Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eugene Frederick Burr</u>		4. DATE OF DEATH <u>August 19 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 20 1887</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Worcester - Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reuben Rosen Burr</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Abbott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give way or dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>Mr. Silver Spring</u>	
17. INFORMANT <u>Mrs. Deulah B. Burr</u>		Address <u>422 Pershing Dr. Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arrest (Heart Block)</u> DUE TO (b) <u>Left Bundle Branch Block</u> DUE TO (c) <u>Auricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>25 years</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1 1940</u> to <u>Aug 19 1967</u> , that (I) (we) last saw the deceased alive on <u>June 15 1967</u> , and that death occurred at <u>120</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>George L. Ball</u>		22b. DATE SIGNED <u>Aug 19 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		22d. ADDRESS <u>10620 Georgia Ave Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>AUG 23 - 1967</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>DALTON NATIONAL</u>		23d. LOCATION (City, town or county) (State) <u>DALTON MD.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>AUG 22 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

VR #15 (4)
20M 1/65



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 393
10-5-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11149

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11150

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md</u> COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>				c. LENGTH OF STAY IN lb <u>7 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>				e. STREET ADDRESS <u>7535 Carroll Ave</u>			
3 NAME OF DECEASED (Type or print) <u>Enriqueta none Cabrera</u>				4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1967</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>7-15-32</u>	
9 AGE (In years last birthday) <u>35 yrs</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Ecuador</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ecuador</u>		13. FATHER'S NAME <u>Esteban Cabrera</u>	
14. MOTHER'S MAIDEN NAME <u>Carmen Cabrera</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>unknown</u>		17. INFORMANT Address <u>Hospital Record</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis, viral</u> DUE TO (b) <u>300X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>(N)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>11111</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>				ASSISTANT MED. CA. EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>23 Aug. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR <u>Rinaldi Funeral Home, Inc.</u>				25a. REC'D BY REGISTRAR <u>Aug 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23d. LOCATION (City or town) (County) (State) <u>Guayaquil, Ecuador</u>				22. DATE SIGNED <u>8/16/1967</u>			



11151

CERTIFICATE OF DEATH

Glenn Falls, N.Y.

11150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital an attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>NEW YORK-WARREN</u> COUNTY <u>Glenn Falls, N.Y.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Md.</u>		c. LENGTH OF STAY IN It <u>1 yr. 3 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>106 LAWRENCE STREET</u>	
3 NAME OF DECEASED (Type or print) <u>Lucille Casey</u>		4 DATE OF DEATH Month <u>Aug.</u> Day <u>14</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 16 - 1906</u> 61 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>N. Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Percy Lasher</u>		14. MOTHER'S MAIDEN NAME <u>Rora Martin Lasher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>085164839</u>	
17. INFORMANT <u>Walter Casey</u>		Address <u>2810 Cheverus and. md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>acute Pyelonephritis, Parkinsonism</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>66</u> , to <u>8/14</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>8/14</u> , 19 <u>67</u> , and that death occurred at <u>11 A.M.</u> , from causes on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack M.D.</u>		22b. DATE SIGNED <u>8/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack M.D.</u>		22d. ADDRESS <u>4115 Colie Pk., Wheaton Md.</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/18/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>SOUTH GLEN FALLS, N.Y.</u>
24. FUNERAL DIRECTOR <u>W.W. Hamber, Inc.</u>		25a. REC'D BY REGISTRAR <u>1400 Chapin St. N.W.</u>	
25b. REGISTRAR'S SIGNATURE <u>W. W. Hamber, Inc.</u>		DATE <u>AUG 17 1967</u>	

10/10/10

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11152

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>10624 Kenilworth Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE Rowley CASSIDY</u>		4. DATE OF DEATH Month Day Year <u>Aug 9 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 3 1898</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I WW II</u>		16. SOCIAL SECURITY NO. <u>261-80-5022</u>	
17. INFORMANT <u>Son</u>		1701 R Street, N.W. Washington, D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>Yes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>date</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2 Aug</u> 19 <u>67</u> , and that death occurred at <u>8:30</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>John G. Ball</u>		22b. DATE SIGNED <u>8/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN G. BALL</u>		22d. ADDRESS <u>7936 Old Georgetown Rd. Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-14-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 21 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Patient of Dr. Harold Heiges. Cleared with coroner, Dr. Reep.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						
c. LENGTH OF STAY IN 1b <u>6 months</u>					d. STREET ADDRESS <u>2101 Hildarose Drive</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bella Vista Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Christine</u> Last <u>Catania</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1967</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1884</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>William A. Keithley</u>					14. MOTHER'S MAIDEN NAME <u>Josephine Hurley</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>579-05-2380 A</u>		17. INFORMANT <u>Olive L. Coppley</u> Address <u>2101 Hildarose Drive Silver Spring, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thromboses (multiple)</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture hip Feb 1961</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs - 1 mo</u> <u>20 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>12 Aug</u> , 19 <u>67</u> , to <u>23 Aug</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Not seen</u> 19 <u> </u> , and that death occurred at <u>1255M</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>John D. Griswold MD</u>						22b. DATE SIGNED <u>23 Aug 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>John D. Griswold, M.D.</u>						22d. ADDRESS <u>4830 V. St. N.W. D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>August 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u>			23d. LOCATION (City, town or county) (State) <u>Port Myer Virginia</u>			
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>John B. Thomas</u> <u>Warner E. Pumphrey</u>						25a. REC'D BY REGISTRAR <u>AUG 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> </div>																			
<p>1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery</p>															
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring</p>				<p>c. LENGTH OF STAY IN 1b Holy Cross Hospital</p>				<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring</p>				<p>d. STREET ADDRESS 1907 Alberti Drive</p>							
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital</p>				<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>															
<p>3. NAME OF DECEASED (Type or print) First Elizabeth Middle J Last Cease</p>				<p>4. DATE OF DEATH Month August Day 31 Year 1967</p>															
<p>5. SEX Female</p>		<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 1/9/1875</p>		<p>9. AGE (In years last birthday) 92 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 2 Hours 1 Min. 0</p>											
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>				<p>11. BIRTHPLACE (County & State, or foreign country) Pennsylvania</p>				<p>12. CITIZEN OF WHAT COUNTRY? USA</p>							
<p>13. FATHER'S NAME Frederick Reynolds</p>						<p>14. MOTHER'S MAIDEN NAME Leveinia Robbins</p>													
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</p>				<p>16. SOCIAL SECURITY NO.</p>				<p>17. INFORMANT Doretha Eckell</p>				<p>Address</p>							
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Thrombosis 1058 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Colon OUE TO (c)</p>												<p>INTERVAL BETWEEN ONSET AND DEATH 1 day</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>																			
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>																			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>								<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>											
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19</p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>				<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>							
<p>21. I certify that (I) (this hospital) attended the deceased from February, 1967 to 8/31, 1967, that (I) (we) last saw the deceased alive on 8/31, 1967, and that death occurred at 11:45 P.M. from the causes and on the date stated above.</p>																			
<p>22a. SIGNATURE Barton J. Gershen</p>												<p>22b. DATE SIGNED 9/1/67</p>							
<p>22c. PHYSICIAN'S NAME (Type) Barton J. Gershen, M.D.</p>												<p>22d. ADDRESS Tenley Bldg., Rockville, Md.</p>							
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>				<p>23b. DATE THEREOF 9/4/67</p>				<p>23c. NAME OF CEMETERY OR CREMATORY Edgehill Cemetery</p>				<p>23d. LOCATION (City, town or county) (State) Nanticoke Pa</p>							
<p>24. FUNERAL DIRECTOR Lee Funeral Home</p>								<p>25a. REC'D BY REGISTRAR SEP 5 1967</p>								<p>25b. REGISTRAR'S SIGNATURE Charles Jones</p>			
<p>ADDRESS Washington, D. C.</p>								<p>DATE</p>											



11154

CERTIFICATE OF DEATH

11155

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE MARYLAND b. COUNTY MONT.	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) SAME		c. LENGTH OF STAY IN 1b 3 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SAME		d. STREET ADDRESS 2435 BEL PRE ROAD	
3 NAME OF DECEASED (Type or print) LURA ANGELINE CILLEY		4. DATE OF DEATH Month 8 Day 31 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1880
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 8 Days 31 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY ---	
11 BIRTHPLACE (County & State, or foreign country) NEW YORK STATE		12 CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME OSIAS WOOD		14. MOTHER'S MAIDEN NAME ANGELINE COON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 220-54-2097	
17 INFORMANT DAUGHTER		Address SAME AS ABOVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL ISCHEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost TERM. (b) TERMINAL PULM. CONGESTION (c) A.S. C.V.D. TERM. YRS.		INTERVAL BETWEEN ONSET AND DEATH TERM.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTHRITIS - SENILE EMPHYSEMA - UREMIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 1966 to 8/31 , 1967, and that (II) (we) last saw the deceased alive on 8/31 , 1967, and that death occurred at 12:30 M, from causes and on the date stated above.			
22a. SIGNATURE Donald R. Lewis		22b. DATE SIGNED 8/31/67	
22c. PHYSICIAN'S NAME (Type) DONALD R. LEWIS		22d. ADDRESS 700 CLOVERLY ST. SILVER SPR. Md	
23a. BURIAL, CREMATION, REMOVAL Interment	23b. DATE THEREOF Sept. 2 1967	23c. NAME OF CEMETERY OR CREMATORY Warrensburg	23d. LOCATION (City or Town) (County) (State) Warrensburg New York
24. FUNERAL DIRECTOR Francis H. Barber		25a. REC'D BY REGISTRAR Laytonsville Md.	
25b. REGISTRAR'S SIGNATURE SEP 7 1967		25c. REGISTRAR'S SIGNATURE Thomas J. Jones	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

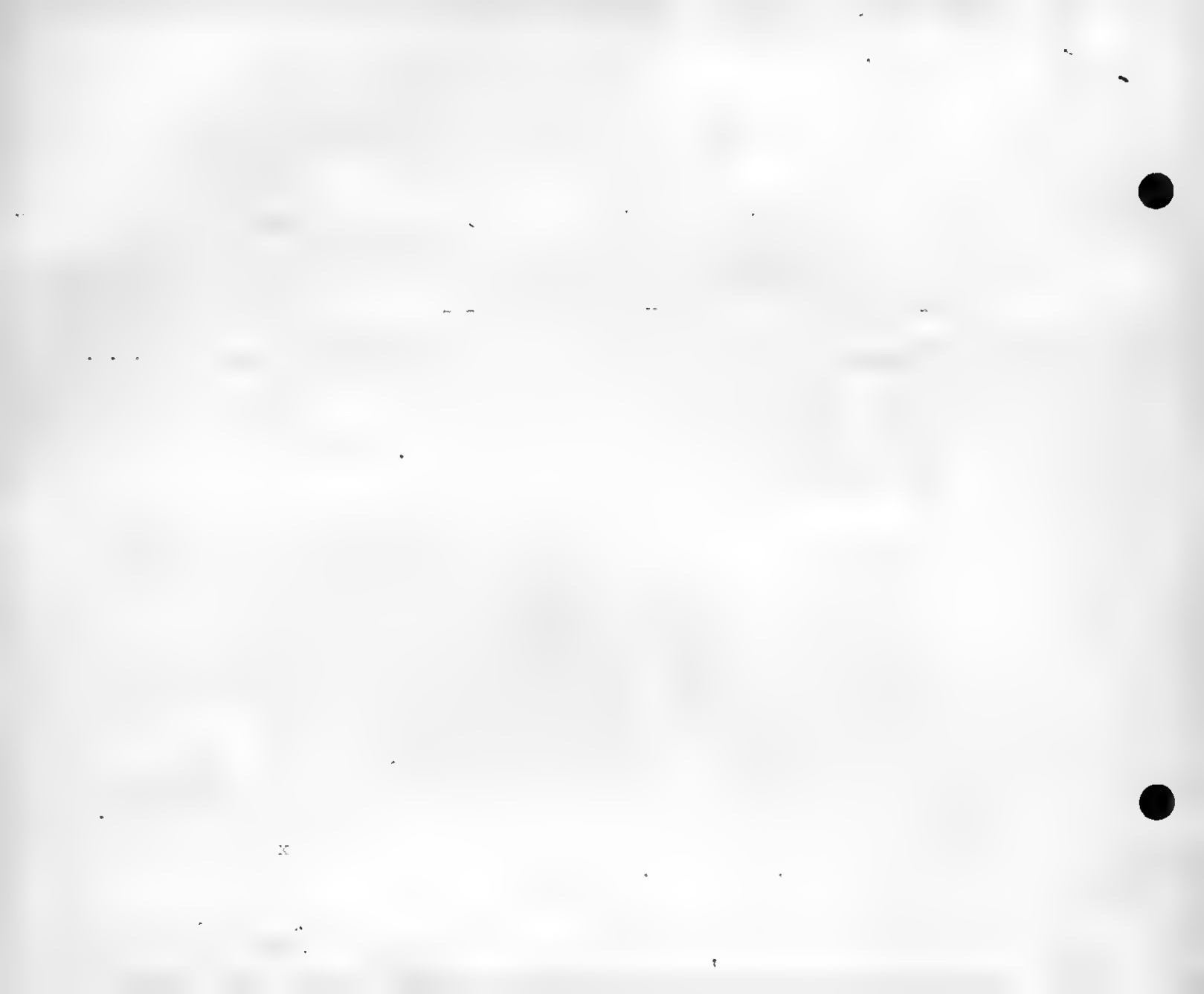
11155

FOR STATE
HEALTH DEPT

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 5206 Elsmere Avenue	
3. NAME OF DECEASED (Type or print) Collins Maria Lucca		4. DATE OF DEATH Month 8 Day 24 Year 19 67	
5. SEX 87- Fe	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 87
9. US. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10. BIRTHPLACE (State or foreign country) Cecil MD Maryland	
11. FATHER'S NAME Friederich von Versen		12. MOTHER'S MAIDEN NAME Julia ?	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		14. SOCIAL SECURITY NO 577-46-7680A	
15. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute bronchopneumonia, 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) bilateral; Arteriosclerotic (c) heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Wheaton, Md. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
EXAMINER'S NAME (Type) Belden R. Reap, M.D.		22. DATE SIGNED 8/25/1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-28-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE AUG 28 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

11156

11157

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Rt. 109 Corners Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl Cooper</u>		4. DATE OF DEATH <u>Aug. 19 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/19/67</u>
9. AGE (In years last birthday) <u>11</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Barbara A. Cooper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mother's chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>7625</u> IMMEDIATE CAUSE (a) <u>Respiratory Distress</u> DUE TO (b) <u>atelectasis</u> DUE TO (c) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 9, 1967</u> to <u>Aug. 19, 1967</u> that (I) (we) last saw the deceased alive on <u>Aug. 19, 1967</u> and that death occurred at <u>7 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>F. J. Wendle</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Mrs. Amelia C. Carter Administrators</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>AUG 24 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11157

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>MONTGOMERY CO</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>DIST. OF COL.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WASHINGTON</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Althea Woodland Nursing Home</i>		d. STREET ADDRESS <i>8000 - PARKSIDE LANE, N.W.</i>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>EDITH I. DAVENPORT</i>		4. DATE OF DEATH Month Day Year <i>8 3 1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>APRIL 23, 1874</i>
9a. AGE (In years last birthday) <i>93</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>---</i>	
11. BIRTHPLACE (State or foreign country) <i>SWITZERLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOHN E. ANDROS</i>		14. MOTHER'S MAIDEN NAME <i>JULIA DYERMAN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>---</i>		16. SOCIAL SECURITY NO. <i>574-66 1481</i>	
17. INFORMANT <i>FREDERICK M. DAVENPORT - SON - 115-5 AVE.</i>		Address <i>NEW YORK, N.Y.</i>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Infarct</i> DUE TO <i>7500</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Atherosclerosis</i> DUE TO <i>and Thrombophlebitis</i> (c) <i>20 years</i> <i>2-3 months</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1960</i> , 19 <i>8-3-</i> <i>1967</i> , that I last saw the deceased alive on <i>7-28</i> , 19 <i>67</i> , and that death occurred at <i>12:10 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James T. Burns</i> M.D.		DATE SIGNED <i>8-3-67</i>	
PHYSICIAN'S NAME (Type) <i>JAMES T. BURNS MD</i>		<i>Washington DC 20006</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>8-5-1967</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland, Md.</i>	
23 FUNERAL DIRECTOR'S SIGNATURE <i>Joseph ...</i>		ADDRESS <i>...</i>	
24a. REC'D BY REGISTRAR <i>AUG 8 1967</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11159											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC.</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. LENGTH OF STAY IN 1b <u>3 mo</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Elizabeth E Day</u>						4. DATE OF DEATH <u>Aug 29 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 20, 1888</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Gr. Falls, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U-S</u>	
13. FATHER'S NAME <u>Gibbs</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>George E. Day, 3301 Prospect St NW, Wash. D.C.</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Effluency of done</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cholera</u> DUE TO (c) <u>Long bodily breakdown - back trouble of 10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/26, 1967</u> to <u>8/1</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/29/ 1967</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Chas H Wolohin</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolohin</u>						22d. ADDRESS <u>831 University Blvd. E. S. I. Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>SEPT. 2, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>				23d. LOCATION (City, town or county) (State) <u>Pp. Geo. Co., Md</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers & Co. Inc</u> <u>3072 M St. N.W., Wash. D.C.</u>						25a. REC'D BY REGISTRAR <u>AUG 31 1967</u>					
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/66

<div>5th 11159</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>11150</div>									
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>18. 11 min.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>					d. STREET ADDRESS <u>5601 Southview St</u>			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Mary Elizabeth Denchfield</u>					4 DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1967</u>				
5 SEX <u>F</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Nov. 18 1965</u>		9 AGE (In years of birthday) <u>14</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Dist. of Columbia.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard Denchfield,</u>					14. MOTHER'S MAIDEN NAME <u>Kathleen Carlson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Mother, (same as Item 2 above)</u> Address				
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>7561</u> IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO <u>Volvulus of proximal colostomy segment</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Imperforate anus, congenital</u> (c) <u>20 months</u>								INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>24 hours</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>0 m.</u> <u>19</u> pm			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/14/67</u>				
					Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery,</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md.</u>			
24. FUNERAL DIRECTOR <u>H. Don DeVol</u> ADDRESS <u>2222 Wis. Ave. N.W.</u>				25a. REC'D BY REGISTRAR <u>Washing, D.C. 20007</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 16 1967</u>	



CERTIFICATE OF DEATH

11161

11160

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. In any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN lb <u>LIFE</u>		d. STREET ADDRESS <u>12708 GOULD RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CRAIG</u> Middle <u>William</u> Last <u>DICE</u>		4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/20/67</u>
9. AGE (In years last birthday) <u>1 HOUR</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>BRUCEA DICE</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE LOUISE SHENK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory & Respiratory failure</u> DUE TO (b) <u>Congenital Malformation (Aneurysm)</u> DUE TO (c) <u>last.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-20</u> , 19 <u>67</u> , to <u>8-20</u> , 19 <u>67</u> , that (I) (we) later saw the deceased alive on <u>8-20</u> , 19 <u>67</u> , and that death occurred at <u>12:41 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Wallace H. McCane</u>		22b. DATE SIGNED <u>8/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wallace H. McCane M.D.</u>		22d. ADDRESS <u>911 Silver Spring Ave. Silver Sp. Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler-Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 23 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>9326 Harvey Road</u>	
3 NAME OF DECEASED (Type or print) <u>Bettie Leoma Dickinson</u>		4 DATE OF DEATH <u>August 4 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-25-90</u>
9 AGE (In years lost birthday) <u>77</u> yrs		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> IF UNDER 24 HRS Hours <u>10</u> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Maurice Downs</u>		14 MOTHER'S MAIDEN NAME <u>Mary Berry</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>219-48-2958</u>	
17 INFORMANT <u>Mrs. John P. Madoney</u> Address <u>9326 Harvey Rd. Hospital Records - Washington Sanitarium & Hospital</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic mammary carcinoma</u> DUE TO (b) <u>Adenocarcinoma right breast</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>Jan 4</u> , 19 <u>67</u> , to <u>Aug 4</u> , 19 <u>67</u> , that (I) (the) last saw the deceased alive on <u>Aug 4</u> , 19 <u>67</u> , and that death occurred at <u>1:55 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Harry N. Carlton</u> M.D.		22b DATE SIGNED <u>Aug 4, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Harry N. Carlton</u>		22d ADDRESS <u>909 Pershing Dr., Silver Spring, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Aug 9, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24a FUNERAL DIRECTOR <u>Thomas E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a REC'D BY REGISTRAR <u>AUG 8 1967</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11162

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3905 Washington Street		d. STREET ADDRESS 3905 Washington Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SARAH M. DINNEL		4. DATE OF DEATH August 14, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/21
9. AGE (in years lost birthday) 46 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roderick Adams		14. MOTHER'S MAIDEN NAME Katherine Hutton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO 212-20-1209	
17. INFORMANT Dr. Page T. Dinnel - Item # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of Breast DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 18, 1967 to Aug 14, 1967 , that (I) (we) last saw the deceased alive on Aug 14, 1967 , and that death occurred at 6:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Blaine H. Eig		22b. DATE SIGNED Aug 15, 1967	
22c. PHYSICIAN'S NAME (Type) Blaine H. Eig		22d. ADDRESS 8641 Colesville Road, Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/17/67	23c. NAME OF CEMETERY OR CREMATORY Woodside	23d. LOCATION (City or Town) (County) (State) Brinklow, Montg., Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1351 Rockville Pike		25a. REC'D BY REGISTRAR AUG 17 1967	25b. REGISTRAR'S SIGNATURE James Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11163

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11164

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		2. USUAL RESIDENCE (Where deceased lived, if not in an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4400 East West Highway</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Dixon</u> Last <u>Dixon</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/13/30</u>
9. AGE (In years) last birthday <u>36</u> yrs		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Gladys Whalen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1951-1953</u>		16. SOCIAL SECURITY NO. <u>578-36-7782</u>	
17. INFORMANT <u>Mary E Dixon - wife</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thyroid with metastasis to heart</u> DUE TO (b) <u>247A</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>last</u>		INTERVAL BETWEEN ONSET AND DEATH <u>month</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>aug 4, 1967</u>	
22. DATE SIGNED		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
25a. REC'D BY REGISTRAR <u>AUG 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



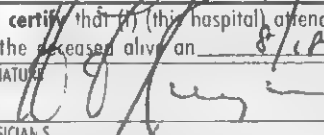

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS 151 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 15 1/2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Nursing Home		d. STREET ADDRESS 4219 McCain Court	
3. NAME OF DECEASED (Type or print) FRANZICA FRANZICA BOSS		4. DATE OF DEATH Month August Day 18 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1878
9. IF (In years of birthday) 88		10. IF UNDER 1 YEAR Months 8 Days 18 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Pfeifer		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Fannie Tatz		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease DUE TO (b) generalized arteriosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (c) INTERVAL BETWEEN ONSET AND DEATH 18 yrs 30 yrs			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/1 , 19 67 , to 8/18 , 19 67 , that (I) (we) last saw the deceased alive on 8/18 , 19 67 , and that death occurred at 1 A M, from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 8/18/67	
22c. PHYSICIAN'S NAME (Type) Franklin H. Kreuzburg		22d. ADDRESS 7852 - 16th. St., N.W., Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 8/19/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or Town) (County) (State) Prince George Co., Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1351 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR AUG 21 1967	
		25b. REGISTRAR'S SIGNATURE 	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11165

CERTIFICATE OF DEATH

11166

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		c. LENGTH OF STAY IN 1b <i>20 HRS.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>SUBURBAN HOSPITAL</i>		d. STREET ADDRESS <i>5812 Rossmore Dr.</i>	
3 NAME OF DECEASED (Type or print) First <i>KATHRYN</i> Middle <i>WADE</i> Last <i>DOYLE</i>		4 DATE OF DEATH Month <i>Aug</i> Day <i>12</i> Year <i>1967</i>	
5 SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/1/1880</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11 BIRTHPLACE (County & State, or foreign country) <i>IRELAND</i>
12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>WILLIAM WADE</i>	
14. MOTHER'S MAIDEN NAME <i>MARGARET MURPHY</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>NONE</i>		17 INFORMANT <i>Joseph H. Doyle - SON - SAME</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>INTESTINAL OBSTRUCTION</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CANCER of colon</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 DAY</i> <i>38 HRS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>JAN</i> , 19 <i>56</i> to <i>AUG 12</i> , 19 <i>67</i> , that (I) (we) lost <i>saw</i> the deceased alive on <i>AUG 12</i> , 19 <i>67</i> , and that death occurred at <i>2 P</i> M, from causes on and on the date stated above			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <i>8/12/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>DR. LEO J. DONOVAN</i>		22d. ADDRESS <i>8218 WISCONSIN AVE</i>	
23a. BURIAL, CREMATION, or other disposition (Specify)	23b. DATE THEREOF <i>Aug. 15, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Forest Glen, Maryland</i>
24. FUNERAL DIRECTOR <i>Glen Carter, Glen Carter Warner E. Humphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>AUG 17 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Potomac Valley Nursing Home</u>						d. STREET ADDRESS <u>5306 Maryland Drive</u>				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Eugenie DENT Draper</u>						4. DATE OF DEATH Month <u>Aug</u> Day <u>13</u> Year <u>1967</u>					
5. SEX <u>Fe.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1908</u>		9. AGE (In years lost birthday) <u>79</u> yrs		10. UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>Louie Addison DENT</u>						14. MOTHER'S MAIDEN NAME <u>Katherine E. Yost</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Geo. W. Campbell SAME AS 2d</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute -</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Rheumatic Heart Disease -</u> DUE TO (c) <u>Years.</u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.						22. DATE SIGNED <u>8/13/67</u>					
EXAMINER'S NAME (Type) <u>John S. Ball</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <u>Washington, D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-15-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>				23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>						ADDRESS <u>Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>Aug 15 1967</u>		25b. SIGNATURE <u>James A. Judge</u>	



11167

CERTIFICATE OF DEATH

11168

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 29 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		d. STREET ADDRESS WASHINGTON 2910 R. ST. N.W.	
3. NAME OF DECEASED (Type or print) First DOROTHY Middle CONNOR Last DUGGER		4. DATE OF DEATH Month AUGUST Day 9 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 SEPT 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (In years last birthday) 76 yrs.
11. BIRTHPLACE (County & State, or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES H. CONNER		14. MOTHER'S MAIDEN NAME DOROTHY CONNOR (Nee-Atterbury.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 579 60 0274	
17. INFORMANT JOHN H. DUGGER, 2722 OLIVE ST. N.W. WDC		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LYMPHO-SARCOMA, LYMPHOCYTIC TYPE, METASTATIC TO KIDNEY AND POSSIBLY TO BRAIN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11 JULY , 19 67 , to 18 AUGUST , 19 67 , that (I) (we) last saw the deceased alive on 9 AUGUST , 19 67 , and that death occurred at 8:30AM , from causes and on the date stated above.			
22a. SIGNATURE L. W. RAYMOND		22b. DATE SIGNED 9 AUGUST 1967	
22c. PHYSICIAN'S NAME (Type) L. W. RAYMOND		22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL - Cremation	23b. DATE THEREOF 8/11/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory & OAK HILL CEMETERY	23d. LOCATION (City or town) (County) (State) 30th & R STS. WDC
24. FUNERAL DIRECTOR W. Don. DeVol		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
DEVOL FUNERAL HOME, 2222 WISCONSIN AVE, NW, WDC		DATE AUG 11 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

21109

11168

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>8322 Roanoke Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Perry Alexander Dye</u>				4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>19 67</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-15-86</u>		9. AGE (In years last birthday) <u>81</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Alexander Dye</u>				14. MOTHER'S MAIDEN NAME <u>Helen Holmes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>578-05-2928</u>		17 INFORMANT <u>Hospital chart</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Prostate gland</u> DUE TO (b) <u>Metastases.</u> DUE TO (c) <u>Dehydration.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>months.</u> <u>weeks</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February</u> , 19 <u>67</u> , to <u>Aug. 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug. 7</u> , 19 <u>67</u> , and that death occurred at <u>4P</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Hugo G. Graziani, M.D.</u> <u>Dr. R. Sandstrom, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI, M.D.</u>				22d. ADDRESS <u>10101 Good Gln Ave SS. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>8/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County Md</u>	
24 FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>				ADDRESS <u>2901 14th ST. N.W.</u>		25a. REC'D BY REGISTRAR <u>AUG 10 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11168

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11170

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>966 McComb St.</u>	
3 NAME OF DECEASED (Type or print) <u>FREDERICK C. DYSON</u>		4 DATE OF DEATH <u>August 15 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/24/31</u>
9 AGE (In years, months, days) <u>36</u> yrs		10 UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rate, Sales Manager Standard Furniture</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EMECO</u>	
11a. BIRTHPLACE (State or foreign country) <u>Youngstown Ohio</u>		11b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>CLYDE Hubert Dyson</u>		14 MOTHER'S MAIDEN NAME <u>Lucinda Kirchner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes KOREAN</u>		16 SOCIAL SECURITY NO <u>296-28-4442</u>	
17 INFORMANT <u>Ellen Walker Dyson - same - aa #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple, Extreme Injuries</u> DUE TO (b) <u>including fractured skull incurred</u> DUE TO (c) <u>in auto accident.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased driver lost control of car and struck fence on curve in road.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:25 p.m. 8-12-1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (home, farm, factory, street, office, etc.) <u>Street</u>		20f. (City or town) <u>Sunshine</u> (County) <u>Montgomery</u> (State) <u>Md.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURLIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 18, 1967</u>	
23a. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23b. LOCATION (City or Town) <u>Washington</u> (County) <u>D.C.</u> (State) <u>D.C.</u>	
24. FUNERAL DIRECTOR <u>H. Don. DeVol</u> ADDRESS <u>2222 W. 1st Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 21 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11170 CERTIFICATE OF DEATH 11171									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>-</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1900 LYTONSVILLE ROAD</u>					d. STREET ADDRESS <u>1900 LYTONSVILLE RD.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>N.</u> Last <u>EISEN</u>		4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1967</u>							
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-Oct-1889</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>VICE PRESIDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>SAMUEL EISEN</u>			14. MOTHER'S MAIDEN NAME <u>TOBEY KLEIN</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>-</u>		Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS & METASTASES</u> DUE TO (b) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>-</u>								INTERVAL BETWEEN ONSET AND DEATH <u>OVER 6 MOS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>-</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>-</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 27, 1954</u> , to <u>Aug. 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug. 19, 1967</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Israel Kessler,</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug. 20, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>ISRAEL KESSLER, M.D.</u>				22d. ADDRESS <u>5801-16th St., N.W., WASH., D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/21/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u>		23d. LOCATION (City, town or county) (State) <u>FALLS CHURCH, VA</u>			
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u>				ADDRESS <u>4217-9th St., N.W.</u>		25a. REC'D BY REGISTRAR <u>Aug 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

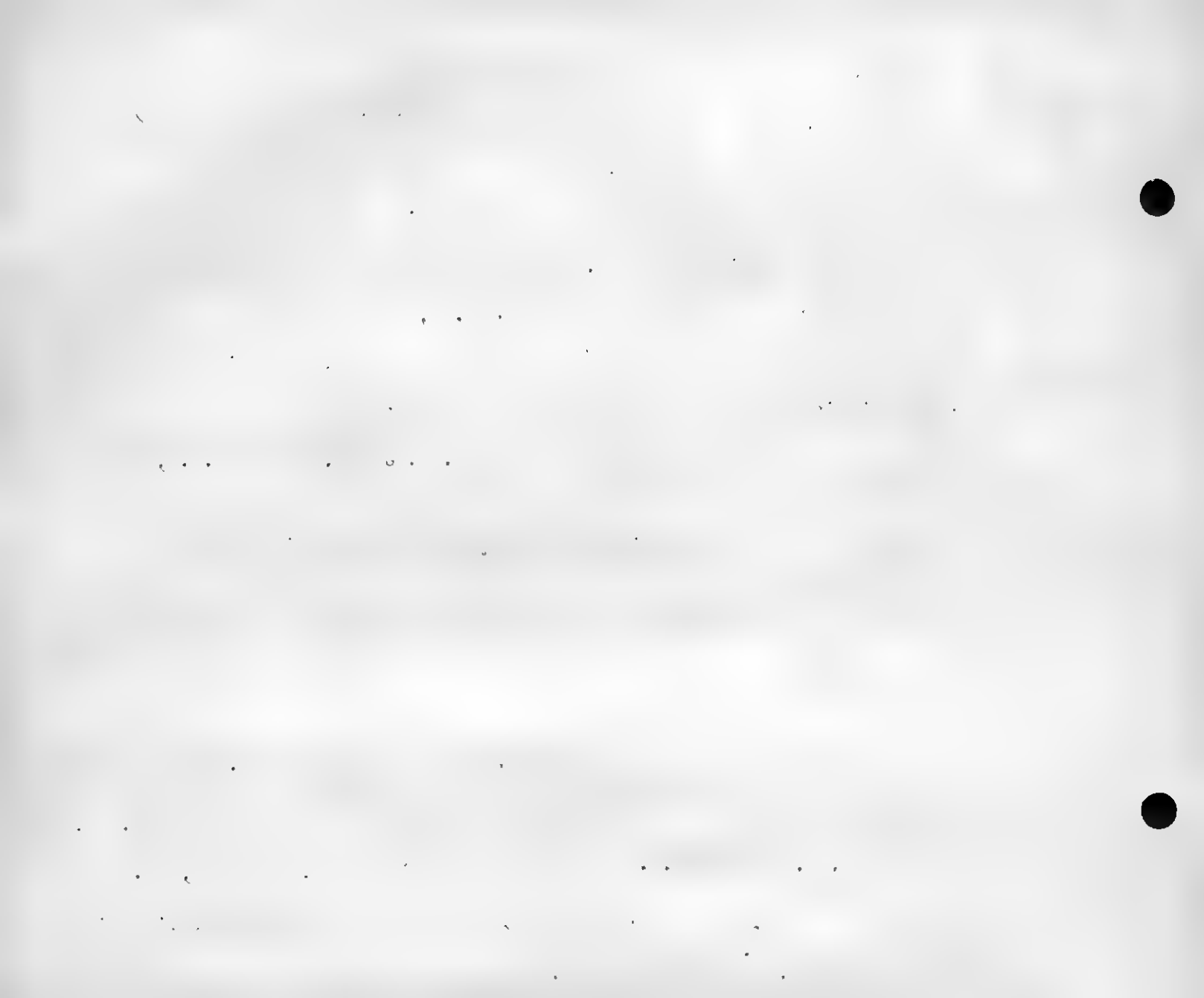
11171

11172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY Warren	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY in Tb 58 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS Belair Avenue	
3. NAME OF DECEASED (Type or print) First Nellie Middle B. Last ELESA		4. DATE OF DEATH Month August Day 24 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1895
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State or foreign country) Clarke County, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James William Bell		14. MOTHER'S MAIDEN NAME Lola Mae Bell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Not avail	
17. INFORMANT Germantown		Address Maryland ICDR L. A. Jones, MC USN R.D.1, Box 178A	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Myocardio Infarct DUE TO Disease (b) Arteriosclerotic Hypertensive Cardiovascular DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from June 27 , 19 67 , to Aug. 24 , 1967, that (2) (we) last saw the deceased alive on August 24 , 19 67 , and that death occurred at 315P M, from causes and on the date stated above.			
22a. SIGNATURE Lawrence W. Raymond		22b. DATE SIGNED Aug. 25, 1967	
22c. PHYSICIAN'S NAME (Type) L. W. RAYMOND M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 28, 1967	
23c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery		23d. LOCATION (City or Town) (County) (State) Berryville, Virginia	
24. FUNERAL DIRECTOR Warner E. Pumphrey		25a. REGISTRY SIGNATURE August 29, 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

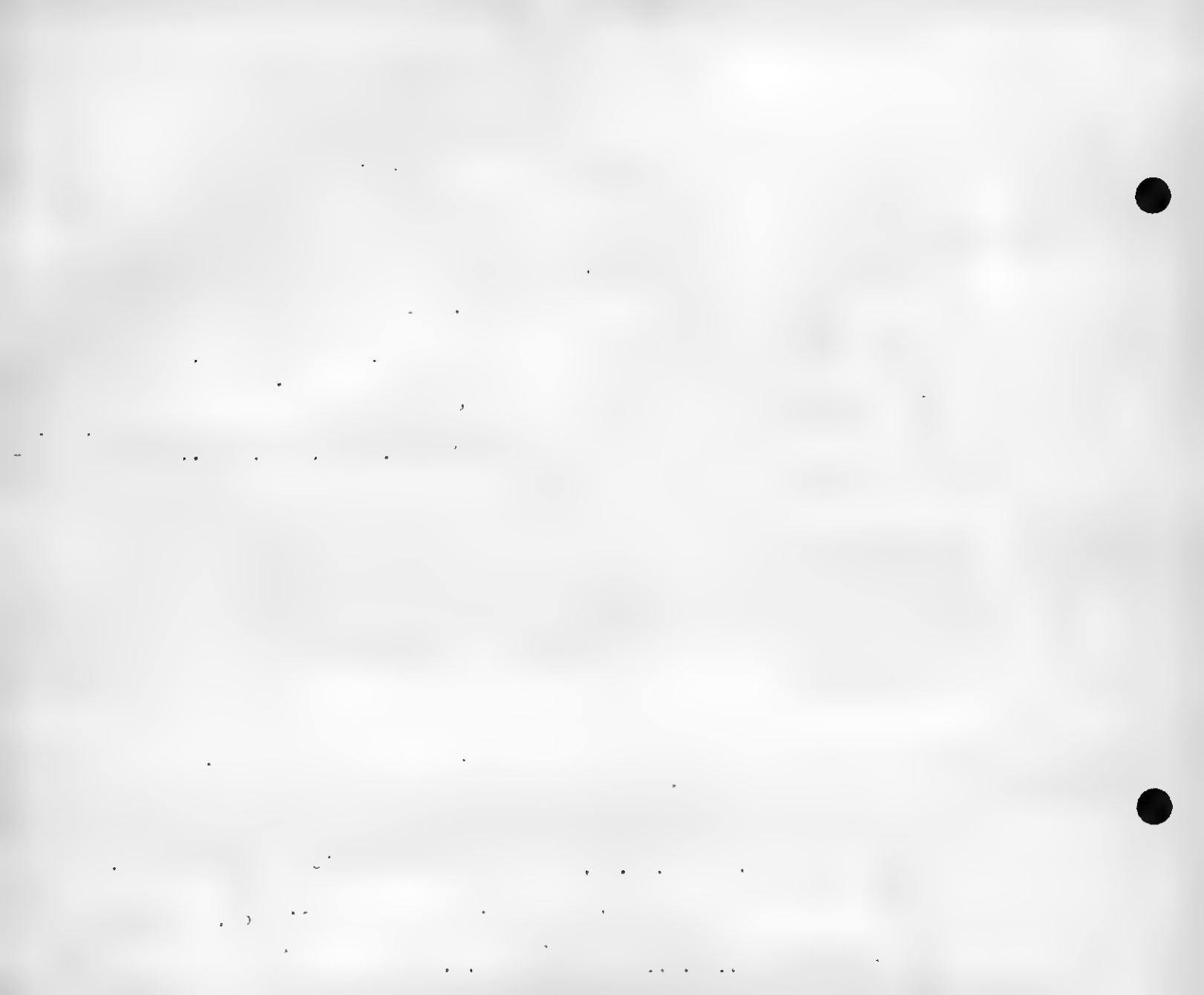
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11172

CERTIFICATE OF DEATH

11173

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Rockville	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN lb 24 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 11125 Stephelee Lane	
3 NAME OF DECEASED (Type or print) First Middle Last Hilda S Saunders ESPE		4 DATE OF DEATH Month Day Year August 24 19 67	
5 SEX Female	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1903
9 AGE (In years last birthday) yrs 64		IF UNDER 1 Year Months Days Hours Min 24 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11 BIRTHPLACE (County & State, or foreign country) Madison, Dorchester Co.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Whitely Saunders		14. MOTHER'S MAIDEN NAME Md. Julia Craig	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. - - - - -	
17 INFORMANT lee Lane		Address Rockville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Breast 110X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 31 July , 19 67 , to 24 Aug. , 19 67 that (X) (we) last saw the deceased alive on 24 Aug. , 19 67 , and that death occurred at 1050AM , from causes and on the date stated above.			
22a SIGNATURE James E. Davis		22b DATE SIGNED 24 August 1967	
22c PHYSICIAN'S NAME (Type) James E. Davis, M. D.		22d ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 8-28-1967	23c NAME OF CEMETERY OR CREMATORY Arlington National	23d LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Joseph Gawler & Sons Funeral Home 5130 Wisconsin Ave., N.W., Washington, D.C.		25a REC'D BY REGISTRAR DATE AUG 28 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



CERTIFICATE OF DEATH

11173

11174

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6825 Needwood Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Emma S. Eubank</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/14/1970</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Langford A. Vanborn</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Lowther</u>	
15. WAS DECEASED EVER IN US ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Husband - Harry Eubank</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial infarction</u> DUE TO (c) <u>Coronary arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/17/65</u> , 19 <u>65</u> , to <u>8/21/65</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>8/20/67</u> , 19 <u>67</u> , and that death occurred at <u>955</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Henry C. Serwogsky M.D.</u>		22b. DATE SIGNED <u>8/21/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or town) (County) (State) <u>Washington DC.</u>
24. FUNERAL DIRECTOR <u>GARTNER'S FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



11174

11175

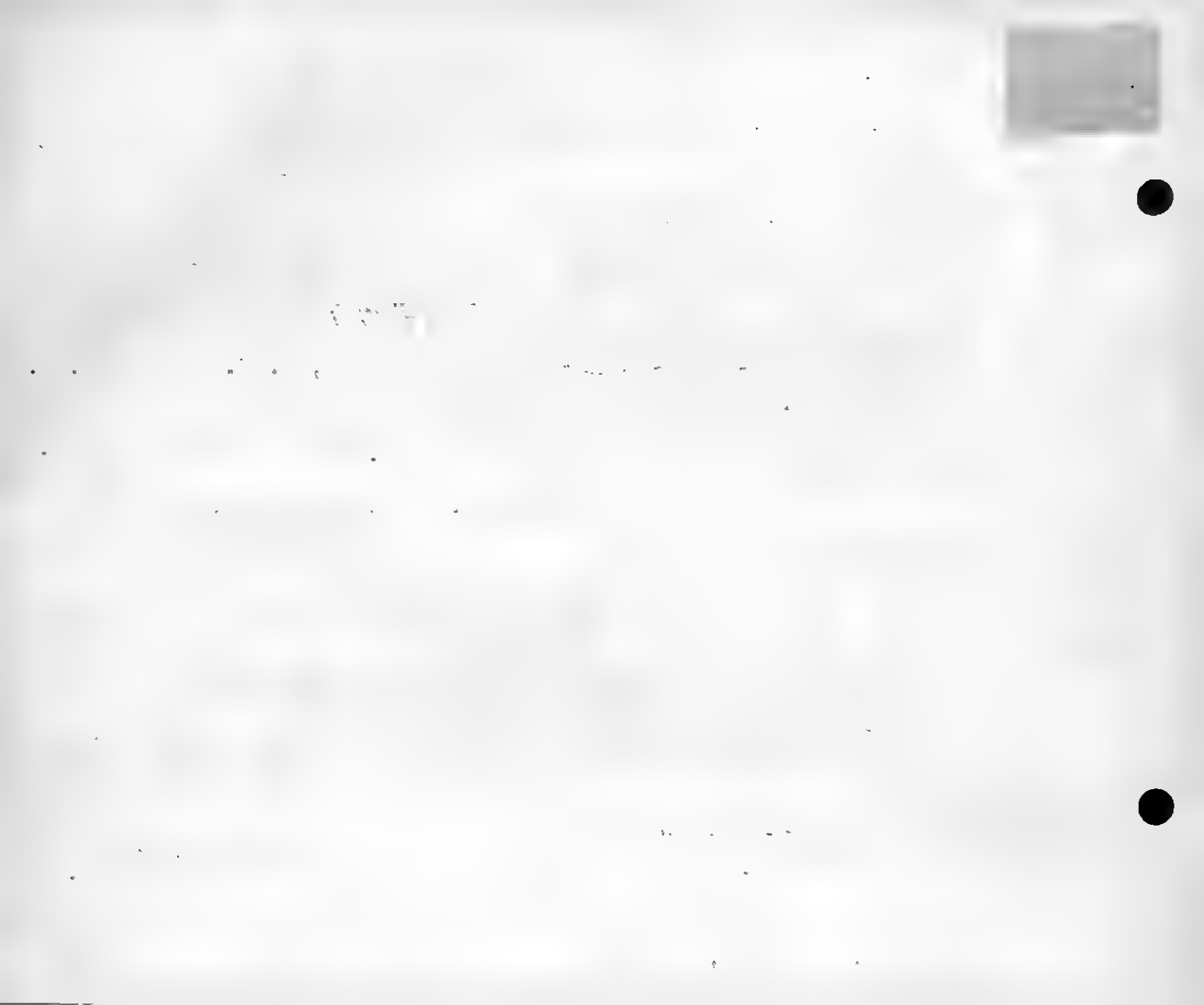
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cabin John</u>		c LENGTH OF STAY IN 1b <u>Cabin John</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7905 Woodrow Place</u>		d STREET ADDRESS <u>7905 Woodrow Place</u>	
3 NAME OF DECEASED (Type or print) <u>Floyd William</u>		4 DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1967</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 9, 1917</u>
9 AGE (in years last birthday) <u>50</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Map Service-Govt - Retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11 BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13 FATHER'S NAME <u>Ulysses S. Evans</u>		14 MOTHER'S MAIDEN NAME <u>Christinia Letelier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>		16 SOCIAL SECURITY NO. <u>WW II</u>	
17 INFORMANT <u>Wife</u>		Address <u>Marjorie L. Evans</u> Same as Item 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Smoke inhalation & 2nd. & 3rd. degree burns, 70% body area</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.?</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>Fell asleep while smoking lying on couch</u>	
20c TIME OF INJURY Month, Day Year Hour <u>4:30</u> pm <u>8/27</u> 19 <u>67</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bag, etc.) <u>Home</u>
20f (City or town) <u>Cabin John, Mont. Md</u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>8/28/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>8-31-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR DATE <u>AUG 31 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

Item 18 Film 393

10-5-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11175

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11176

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY PR Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN TB 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital				d. STREET ADDRESS 404 Elm Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Richard Mark Fann				4. DATE OF DEATH Month Day Year August 18 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-60	9. AGE (In years last birthday) 7 yrs	10. IF UNDER 1 YEAR Months Days Hours Mins 7 yrs	11. UNDER 24 HRS Months Days Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME George M. Fann				14. MOTHER'S MAIDEN NAME Violet Mailhot			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT Patient's chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries with DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) intracranial hemorrhage DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Child rode bike in front of car.							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Child rode bike in front of car.			
20c. TIME OF INJURY Month Day Year 4:45 p.m. 8-9 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Street		20f. (City or town) (County) (State) Takoma Park Prince George's Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF August 22-1967			
23c. NAME OF CEMETERY OR CREMATORY St. Ignace Cemetery				23d. LOCATION (City or town) (County) (State) Beltsville Prince Georges Md.			
24. FUNERAL DIRECTOR Arthur Walters				25. REGISTRAR'S SIGNATURE Charles Judge			
25a. RECORD BY REGISTRAR DATE AUG 22 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

11176

CERTIFICATE OF DEATH

11177

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		d. STREET ADDRESS <u>104 Pine Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Richard Paul Farmer</u>		4. DATE OF DEATH <u>8-4</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-49</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>17</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul O. Farmer</u>		14. MOTHER'S MAIDEN NAME <u>Leila Heeshey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Leila Farmer-mother</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Hydronephrosis & pyelonephritis, acute & chronic</u> DUE TO (c) <u>Neurogenic bladder due to meningocele</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u>67</u> to <u>8/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/4</u> , 19 <u>67</u> , and that death occurred at <u>10:00</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Timothy J. Tehan M.D.</u>	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>8/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Timothy J. Tehan</u>	22d. ADDRESS <u>8218 Wis. Ave. N.W. Bethesda Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>8-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	23d. LOCATION (City or town) (County) (State) <u>Bladensburg PG Md.</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>AUG 7 1967</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11177

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>Washington, DC</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		d. STREET ADDRESS <u>6216-7th St NW</u>	
3. NAME OF DECEASED (Type or print) First <u>CECILIA</u> Middle <u>Fields</u> Last <u>Fields</u>		4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-10</u>
9. AGE (In years last birthday) <u>57</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Edward Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Ido Hunt - Sister - Same as above</u>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4330</u> DUE TO (b) <u>Ventricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>Indeterminate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension & C.V.A.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> , 19 <u>67</u> , to <u>8/29</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>8/29</u> , 19 <u>67</u> , and that death occurred at <u>2:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen N. Jones</u>		22b. DATE SIGNED <u>8/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>		22d. ADDRESS <u>Rockville, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DAY THEREOF <u>9-2-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>K. Jones Co</u>		25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. DATE <u>SEP 5 1967</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11178

CERTIFICATE OF DEATH

11179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove arban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 20 days		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Olney	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS Box 73	
3. NAME OF DECEASED (Type or print) Florence Elizabeth Finneyfrock		4. DATE OF DEATH Month August Day 4 Year 19 67		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/90	9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Reuben Hines		14. MOTHER'S MAIDEN NAME Mary Burriss	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-34-1061D		17. INFORMANT Medical Records Address	
18. CAUSE OF DEATH (Enter only one cause possible for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myocardial failure DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH yes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1956 to 8/4/67 , that (I) (we) last saw the deceased alive on 8/4/67 , and that death occurred at 12:35 P.M. from causes and on the date stated above					
22a. SIGNATURE Charles H. Ligon, M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8/4/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Medical Center, Sandy Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial	8-7-67	St. John		Olney	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 8 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11179

11180

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
3. NAME OF DECEASED (Type or print) KATHALEEN R. FISHBACK		4. DATE OF DEATH Month August Day 8 Year 1967	
5. SEX Female	6. COLOR OF SKIN White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1903 9. AGE (In years lost birthday) 63 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) N.M.
13. FATHER'S NAME Alfred Robles		14. MOTHER'S MAIDEN NAME Kate King	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-46-3756	
17. INFORMANT Barbara F. Edwards - Rockville, Md.		18. ADDRESS 5112 Parklawn Ter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED August 9, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Aug. 9, 1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Suitland, Md.		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. Wash., D.C.		25. REC'D BY REGISTRAR Charles Judge	
DATE AUG 14 1967		26. REGISTRAR'S SIGNATURE	



10-11-67 ams

11181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Maryland b. COUNTY Howard	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		d STREET ADDRESS 15 Dellwood Ave.	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Barbara Weeks Fisher		4 DATE OF DEATH Month August Day 10 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/16/32
9 AGE (in years lost birthday) 35 yrs		10 UNDER 1 YEAR Months 1 Days 19	
11 UNDER 24 HRS Hours 19 Min 67			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Radford, Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ira Weeks		14 MOTHER'S MAIDEN NAME Elizabeth	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Husband, Bruce Fisher		Address 15 Dellwood Ave. Ellicott City, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory failure 929.4 DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) due to drowning (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Deceased drowned while swimming	
20c TIME OF INJURY Month, Day, Year Hour 3:25 p.m. 8-10 1967	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Swim. Pool (Club)	20f (City or town) (County) (State) Rte 29 Howard Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Beleen R. Keap		22. DATE SIGNED August 15, 1967	
EXAMINER'S NAME (Type) BELOEN R. KEAP M.D.		Address (Street, City, town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF AUG. 13, 1967	23c NAME OF CEMETERY OR CREMATORY WESTVIEW CEMETERY	23d LOCATION (City or town) (County) (State) RADFORD, VIRGINIA
24 FUNERAL DIRECTOR HARRY H. WILKE		ADDRESS ELLICOTT CITY, MARYLAND	
25a REC'D BY REGISTRAR AUG 15 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
11181															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12 hours</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>1939 Lewis Ave -</u>		6. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1967</u>		7. AGE (in years last birthday) <u>12 yrs.</u>							
3. NAME OF DECEASED (Type or print) <u>Thomas - Edward - Flick</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-26-67</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. IF UNDER 1 YEAR Months <u>12</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>							
13. FATHER'S NAME <u>Samuel L. Flick</u>		14. MOTHER'S MAIDEN NAME <u>Joyce Mart Clark</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joyce Mart Clark</u> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple congenital anomalies</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Bilateral Pulmonary Atelectasis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8 AM 8/26, 1967</u> to <u>6 PM 8/26, 1967</u> that (I) (we) last saw the deceased alive on <u>26 Aug 1967</u> , and that death occurred at <u>6 PM</u> from the causes and on the date stated above.										22a. SIGNATURE <u>Dan Brecher</u> M.D.		22b. DATE SIGNED <u>26 Aug 67</u>		22c. PHYSICIAN'S NAME (Type) <u>50 W. Edmonston Drive, Rockville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		23d. LOCATION (City, town or county) <u>Bethesda-Montg.</u>		23e. (State) <u>MD</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Amelia C. Carter</u>		24b. ADDRESS <u>Administrator</u>		25a. REC'D BY REGISTRAR <u>SEP 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE SIGNED							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

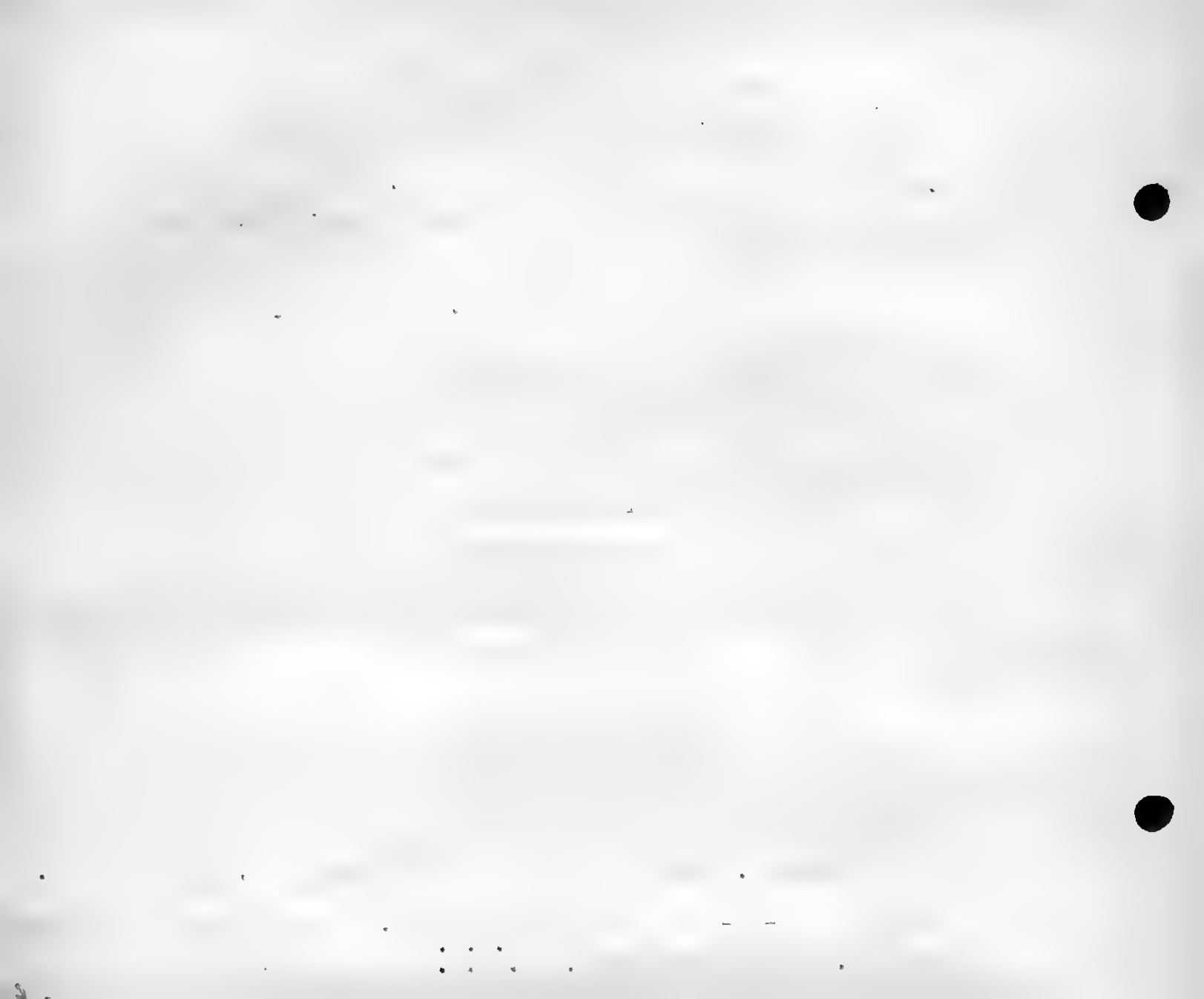
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11182

11183

1. PLACE OF DEATH a. COUNTY <u>Silver Spring, Md.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> c. LENGTH OF STAY IN 1b <u>20 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Silver Spr. Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> d. STREET ADDRESS <u>1007 DALE DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret B. Folk</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/6/13</u>
9. AGE (In years last birthday) <u>53</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Gov. Civil)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT J. BARRETT</u>		14. MOTHER'S MAIDEN NAME <u>THERESA C. WELSH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-44-447</u>	
17. INFORMANT <u>STEPHEN H. FOLK</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary hepatoma</u> DUE TO (b) <u>Hepatic cirrhosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral lobular pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>Aug 17</u> , 19 <u>67</u> , that (I) was last saw the deceased alive on <u>Aug 16</u> , 19 <u>67</u> , and that death occurred at <u>6:30 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>James W. Egan</u>		22b. DATE SIGNED <u>8/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES W. EGAN</u>		22d. ADDRESS <u>5413 CEDAR LANE, BETHESDA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATE of HEAVEN CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>SILVER SPRING, MARYLAND</u>
24. FUNERAL DIRECTOR <u>F. J. Collins</u>		25a. REC'D BY REGISTRAR <u>Francis J. Collins</u>	
ADDRESS <u>WASH. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>	
DATE <u>AUG 21 1967</u>		DATE <u>AUG 21 1967</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If jury de obis necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. LENGTH OF STAY IN TB <u>2 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Spring Nursing Home</u>						d. STREET ADDRESS <u>901 Langley Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Idah S. Foster</u>						4 DATE OF DEATH Month <u>Aug</u> Day <u>13</u> Year <u>1967</u>					
5 SEX <u>Fe.</u>		6 COLOR OR RACE <u>W.</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>July 18, 1884</u>		9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11 BIRTHPLACE (State or foreign country) <u>Tillamook -</u>				12 C. T. ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Andrew Ambuhl</u>						14. MOTHER'S MAIDEN NAME <u>Caroline Wicke</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO <u>577-56-2588</u>		17 INFORMANT <u>Charles F. Pratt (Son)</u> Address <u>901 Langley Dr. Sil. Spg., Md. 20901</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency - Acute</u> DUE TO (b) <u>Coronary Thrombosis -</u> DUE TO (c) <u>Cardio Vascular Disease -</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.						22. DATE SIGNED <u>8/13/67</u>					
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>						Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Bladensburg, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., Wash., D. C.</u>						25a. RECEIVED BY REGISTRAR DATE <u>AUG 17 1967</u>		25b. REGISTERED SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

11184

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY 11	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d STREET ADDRESS 7719 Eastern Avenue	
3. NAME OF DECEASED (Type or print) First Joseph Middle H. Last Frank		4 DATE OF DEATH Month August Day 29 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/3/89
9 AGE (In years lost birthday) 78 yrs		IF UNDER 1 YEAR Months 4 Days 26 Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Manfg. Plant Manager		10b. KIND OF BUSINESS OR INDUSTRY DETROIT, MICHIGAN	
11. BIRTHPLACE (County & State, or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Frank		14. MOTHER'S MAIDEN NAME Ann Sheridan (Frank)	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Not Available	
17. INFORMANT (WIFE) MRS. J.H. FRANK		18. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) Takoma Park, Md. 7719-EASTERN AVENUE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Coronary atherosclerosis DUE TO (c) Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left cerebral infarction.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 12 , 1967, to August 29 , 1967, that (I) (was) last saw the deceased alive on August 28 , 1967, and that death occurred at 1:54 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Aaron H. Traum		22b. DATE SIGNED August 29 1967	
22c. PHYSICIAN'S NAME (Type) Aaron H. Traum, M.D.		22d. ADDRESS 8237 Georgia Ave - Silver Spring, Maryland.	
23a. 23a. DATE OF BURIAL Cremation	23b. DATE THEREOF Aug. 31/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24 FUNERAL DIRECTOR Wm. J. Thompson		25a. REC'D BY REGISTRAR AUG 31 1967	
25b. REGISTRAR'S SIGNATURE William J. Thompson		25c. REGISTRAR'S SIGNATURE William J. Thompson	

Gagnon, Mrs. Maria

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11185

CERTIFICATE OF DEATH

11186

1 PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN Tb <u>14 years</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>511 Pershing Drive</u>		d STREET ADDRESS <u>511 Pershing Drive</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Maria Boulianne Gagnon</u>		4 DATE OF DEATH Month Day Year <u>August 11 19 67</u>	
5 SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 8, 1883</u>
9. AGE (In years last birthday) yrs <u>84</u>		IF UNDER 1 YEAR Months Days Hours Min <u>11 19 67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Canada</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henri Boulianne</u>		14 MOTHER'S MAIDEN NAME <u>Celina Tranley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>219-46-7061</u>	
17. INFORMANT <u>Joseph R. Godbout</u>		Address <u>511 Pershing Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 to <u>August 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 5 1967</u> , and that death occurred at <u>4:00 p.m.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Bennet A. Porter, Jr. M.D.</u>		22b. DATE SIGNED <u>August 11, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr. M.D.</u>		22d. ADDRESS <u>9301 Coleridge Rd, Silver Spring, Md.</u>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>E. Glen Carter, Glen Carter & Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>AUG 17 1967</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G392 9/18/67 ph & Item #8

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY in lb 38 DAYS		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) COLONIAL VILLA NURSING HOME CAMP.		d. STREET ADDRESS 7127 CHESTNUT STREET	
3 NAME OF DECEASED (Type or print) MARY DOLORES GARCIA		4. DATE OF DEATH Month AUGUST Day 31 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 21 1893
9. AGE (In years last birthday) 73 1/2 yrs		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 15 Min 00	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HUSBAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CONSTANTINE FERNANDEZ		14. MOTHER'S MAIDEN NAME ISABELLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 235483902	
17. INFORMANT MRS. CONNIE DRYBURGH, TAKOMA PARK MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Heart Failure DUE TO CVA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH Several months			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-20 , 19 67 , to 8-31 , 19 67 , that (I) (we) last saw the deceased alive on 8-16 , 19 67 , and that death occurred at 7 PM , from causes and on the date stated above.			
22a. SIGNATURE R. H. Sandstrom		22b. DATE SIGNED 8-31-67	
22c. PHYSICIAN'S NAME (Type) R. H. Sandstrom		22d. ADDRESS 7701 Carroll Ave, Takoma Park, Md	
23a. BURIAL OR CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 5, 1967	
23c. NAME OF CEMETERY OR CREMATORY Elk View Masonic Cemetery		23d. LOCATION (City or Town) (County) (State) Clecksburg W. Va	
24. FUNERAL DIRECTOR J. Arthur Walters		25a. RECEIVED BY REGISTRAR 254 Carroll St NW Washington D.C.	
25b. REGISTRAR'S SIGNATURE Charles Jones		DATE SEP 5 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b. <u>72 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRINGS</u> d. STREET ADDRESS <u>95 E. WAYNE AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>A.</u> Last <u>GASKINS</u>		4. DATE OF DEATH Month <u>8</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1907-59</u> 9. AGE (in years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Safeway Food Stores</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>US AMERICA</u>	
13. FATHER'S NAME <u>William H. Gaskins</u>		14. MOTHER'S MAIDEN NAME <u>Doris Gaskins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Eleanor Gaskins</u>		Address <u>95 East Wayne Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Supragastric Cystostomy</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/25, 1967</u> to <u>8/27, 1967</u> , that (I) (we) last saw the deceased alive on <u>8/26/1967</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Timothy T. Egan M.D.</u>		22b. DATE SIGNED <u>8/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>TIMOTHY T. EGAN</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 30, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town or county) (State) <u>Washington, DC</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25. REG'D BY REGISTRAR <u>100</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



11188

CERTIFICATE OF DEATH

11189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1906 VENTURA AVE</u>		d. STREET ADDRESS <u>1906 VENTURA AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>MOSES</u> Middle <u>GILNER</u> Last		4 DATE OF DEATH Month <u>AUGUST</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-1-1883</u>
9. AGE (In years last birthday) <u>84</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUTCHER (RET)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FOOD</u>	11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>UNKNOWN</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, if unknown) (If yes give war or dates of service) <u>NO</u>	
16 SOCIAL SECURITY NO. <u>UNKNOWN</u>		17 INFORMANT <u>LEFTER FUNERAL HOME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PROSTATIC HYPERTROPHY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>JULY 15</u> , 19 <u>67</u> , to <u>AUGUST 13</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 13</u> , 19 <u>67</u> , and that death occurred at <u>4:30 PM</u> , from causes on and on the date stated above.	
22a. SIGNATURE <u>M. S. MADELOFF</u>		22b. DATE SIGNED <u>8/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MICHAEL S. MADELOFF</u>		22d. ADDRESS <u>10620 GEORGIA AVE SILVER SPRING MD</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>BROOKLYN NY</u>
24. FUNERAL DIRECTOR <u>CONDORRE FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>4217 9th St. N.W.</u>	
25b. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>		DATE <u>AUG 15 1967</u>	

111108

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

111100

STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Gaithersburg</u> 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long Drast Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>D</u> Last <u>Glover Jr.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1927</u>
9. AGE (in years last birthday) vis		10. UNDER 1 YEAR Months <u>40</u> Days <u>2</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscape</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William D Glover</u>		14. MOTHER'S MAIDEN NAME <u>Gladys Burdette</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>220-28-5081</u>	
17. INFORMANT <u>Madeline J. Glover</u>		Address <u>405 Dogwood Dr. Gaithersburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Neck and Chest</u> DUE TO (b) <u>751X</u> DUE TO (c) <u>stating the underlying cause last</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Shot with 8mm rifle by another man.</u>	
20c. TIME OF INJURY Month Day Year Hour am - <u>3:15</u> <u>8/26</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Home - yard</u>		20f. (City or town) (County) (State) <u>Rural Gaithersburg Mont-Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>8/26/67</u>	
EXAMINER'S NAME (Type) <u>John G. BALL, M.D.</u>		Address (Street, city, town, or county) <u>316 E. Diamond Ave Gaithersburg</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 29, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Clarksburg Mont-Md.</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>AUG 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11180

CERTIFICATE OF DEATH

11291

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 14 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10507 Weymouth Street				d. STREET ADDRESS 10507 Weymouth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH First GOOKEN Middle Last				4. DATE OF DEATH Aug. 17, 1967 Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1892	9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lowell, Mass.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Tracy				14. MOTHER'S MAIDEN NAME Margaret Curley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-48-3826		17. INFORMANT Husband Address Same as Item 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ACUTE RHEUMATISM DUE TO EMPHYSEMA - CHRONIC (b) DIABETES MELLITUS DUE TO BRONCHITIS (c) SP. GANGRENE OF FOOT INTERVAL BETWEEN ONSET AND DEATH > 15 years > 13 years Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 54 , to Aug 17 , 19 67 , that (I) (we) last saw the deceased alive on August 11 , 19 67 , and that death occurred at 7:19 P.M. , from causes and on the date stated above.							
22a. SIGNATURE Hugo G. Graziani, M.D. for Dr. John Curley				22b. DATE SIGNED 8/17/67			
22c. PHYSICIAN'S NAME (Type) HUGO G. GRAZIANI, M.D.				22d. ADDRESS 10101 GEORGIA AVE, SS. MD.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial-transit 8-21-67		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery, Lowell, Mass.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE AUG 23 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN b <u>4 yrs - 3 mos</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brooke Grove Foundation</u>						d. STREET ADDRESS <u>Colesville Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Bertha</u>		First		Middle <u>Maurine</u>		Last <u>Gordon</u>		4. DATE OF DEATH Month <u>August</u>		Day <u>9th</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 11th</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>9</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Augusta Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>F.M. Patton</u>				14. MOTHER'S MAIDEN NAME <u>J.F. Sullivan</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>344 10 0379</u>				17. INFORMANT <u>Dr. Francis B. Gordon - Colesville Rd - Ashton Md.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>Acute coronary failure</u> <u>Hypertensive C.V. disease</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 day</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>63</u>		(County) <u>8/9</u>		(State) <u>67</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1967</u> to <u>8/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/9</u> , 19 <u>67</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>C.H.A. Gordon</u>						22b. DATE SIGNED <u>8/9/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>C.H.A. Gordon</u>						22d. ADDRESS <u>Sandy Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Aug. 10 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Graceland</u>		23d. LOCATION (City, town or county) <u>Fairbury</u>		(State) <u>Illinois</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>					
25b. REGISTRAR'S SIGNATURE <u>Laytonsville Md.</u>						DATE <u>AUG 11 1967</u>					

1. The first part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right.

11192

CERTIFICATE OF DEATH

11193

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DICKERSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DICKERSON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #2</u>		d. STREET ADDRESS <u>R.F.D. #2</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin R. Graham</u>		4. DATE OF DEATH <u>Aug. 8, 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 12, 1890</u>
9. AGE (In years last birthday) <u>77</u>		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CIT. ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Graham</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Peters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <u>350X</u> IMMEDIATE CAUSE (a) <u>Rockman's Disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Date</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>25 July</u> 19 <u>67</u> , and that death occurred at <u>7 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Lawrence</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Aug. 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Martinsburg Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Martinsburg, Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>AUG 11 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove portion papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11193

CERTIFICATE OF DEATH

11194

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>	
c. LENGTH OF STAY IN TB <u>7 days</u>		d. STREET ADDRESS <u>13133 Oriole Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bernadine Mary Gubisch</u>		4. DATE OF DEATH <u>Aug 13 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-03</u> 64 yrs
9. AGE (In years, lost birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>13</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Worker on Public Schools</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Lawrence Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Onoc</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>Washington Sanitarium-Records</u>	
17. INFORMANT <u>Washington Sanitarium-Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> DUE TO (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>antihypertensive cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 + years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 6</u> , 19 <u>67</u> , to <u>Aug. 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug. 12</u> , 19 <u>67</u> , and that death occurred at <u>8:45 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Robert A. McCormick</u>		22b. DATE SIGNED <u>Aug. 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert McCormick</u>		22d. ADDRESS <u>11161 New Hampshire ave Silver Springs Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Wheaton Montgomery Md.</u>
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 16 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

11194

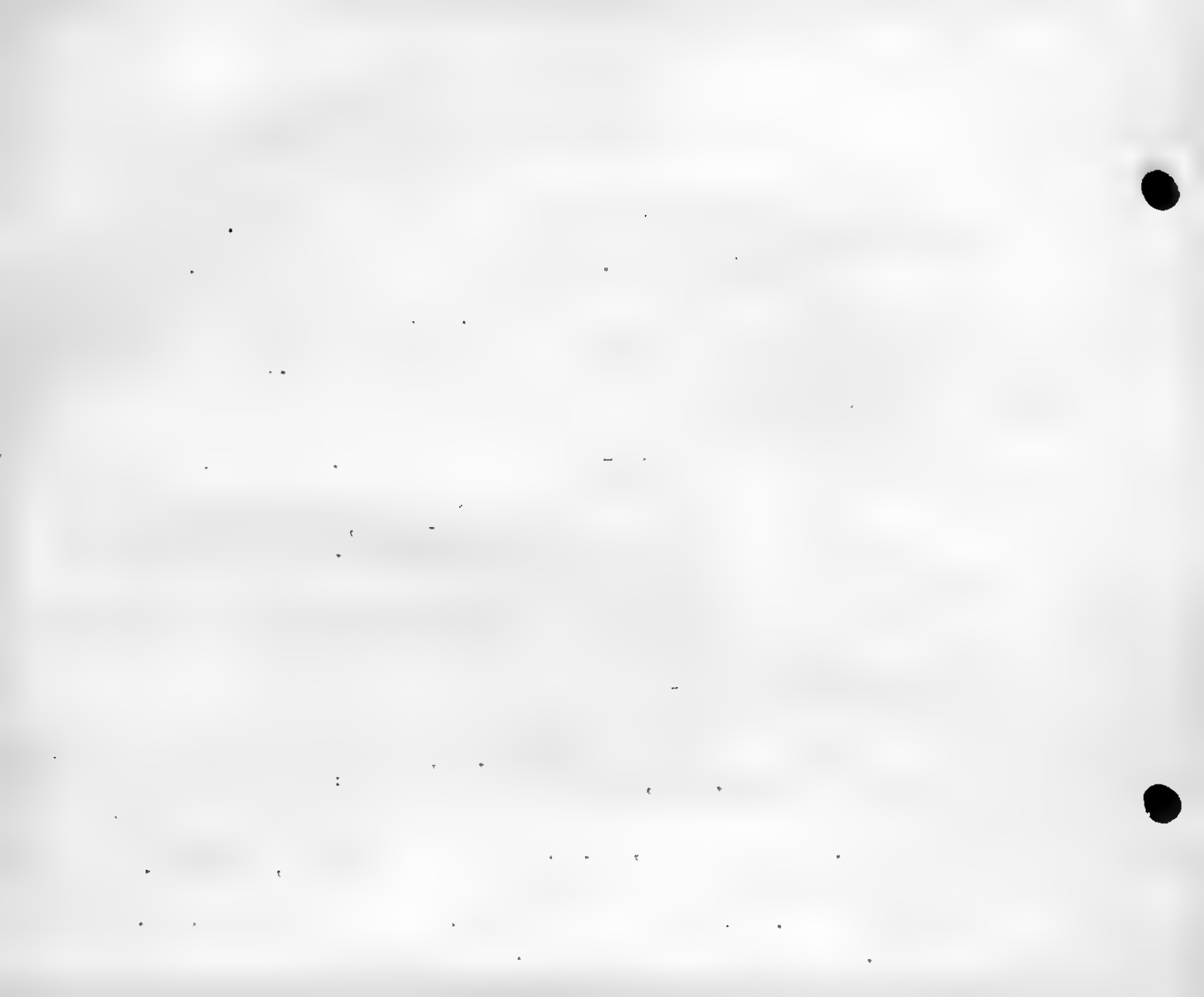
CERTIFICATE OF DEATH

11195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN 15 Damascus		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home			d. STREET ADDRESS 25900 Ridge Rd.		
3 NAME OF DECEASED (Type or print) First Lillie Middle M. Last Hager			4. DATE OF DEATH Month Aug. Day 12 Year 19 67		
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1887		9. AGE (In years last birthday) 80 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (County & State, or foreign country) Montgomery Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward Thompson			14. MOTHER'S MAIDEN NAME Margaret Purdum		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-46-3723	17. INFORMANT Mrs George G. Matthews, Falls Church, Va. Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Arteriosclerotic Cardiovascular Disease DUE TO with Large Fusiform Aneurysm, Hypertension and (b) Terminal Cardiac Decompensation. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 14, 1967 , to August 12, 1967 , that (I) was saw the deceased alive on August 12, 19 67 , and that death occurred at 10:45 A.M. from causes and on the date stated above.					
22a. SIGNATURE M. McKendree Boyer, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/12/67		
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.		22d. ADDRESS 9701 Church Street Damascus, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 15, 1967	23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.	23d. LOCATION (City or Town) (County) (State) Damascus, Md.		
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DATE AUG 16 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



FOR STATE
HEALTH DEPT.

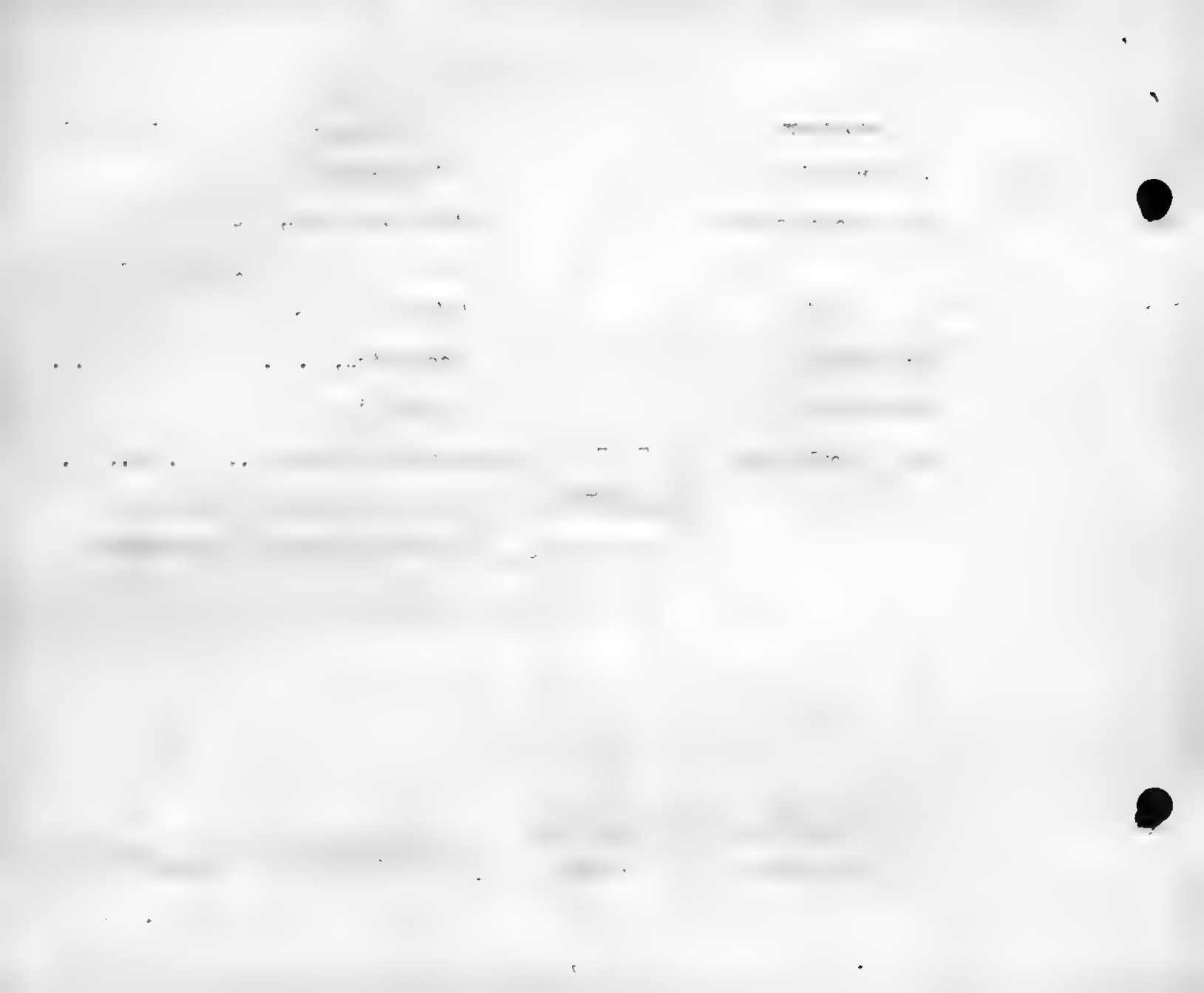
11195

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-1966

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN Ia Silver Spring	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e STREET ADDRESS 8484 16th Street, #907	
3 NAME OF DECEASED (Type or print) First LEE Middle POE Last HART		4 DATE OF DEATH Month August Day 1 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/8/1899
9 AGE (In years last birthday) 68 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Washington, D. C.	
12 CITIZEN OF WHAT COUNTRY? U.S.		13 FATHER'S NAME George Hart	
14 MOTHER'S MAIDEN NAME Mamie Pie		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War I	
16 SOCIAL SECURITY NO. 577-09-8176		17 INFORMANT (Wife) Hazel Hart 8484 16th St., Sil. Sp., Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Coronary Artery Heart Disease DUE TO (c) Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		22. DATE SIGNED August 2, 1967	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 8-4-67	
23c NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d LOCATION (City or town) (County) (State) Washington, D. C.	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a REC'D BY REGISTRAR AUG 7 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11196

CERTIFICATE OF DEATH

11197

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 12 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 6217 30th St N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last KENNETH MAYO HAWKINS			4. DATE OF DEATH Month Day Year AUGUST 25 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1900	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER-RET-DISTRICT SCHOOLS		10b. KIND OF BUSINESS OR INDUSTRY TENN		11 BIRTHPLACE (County & State or foreign country) U.S.A.	
13. FATHER'S NAME RICHARD L. HAWKINS			14. MOTHER'S MAIDEN NAME INEZ MAYO		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 577-10 8356		17. INFORMANT DOROTHY M. HAWKINS - SEE ITEM NO 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart myocardial infarction DUE TO (b) 1 week Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 7/1/67 , 19 67 , to Aug 25, 1967 , that (I) (we) lost saw the deceased alive on 8/24 19 67 , and that death occurred at 8:05 AM , from causes and on the date stated above.					
22a. SIGNATURE Jay R. Shapiro		22b. DATE SIGNED 8/25/67		22c. PHYSICIAN'S NAME (Type) Dr. Jay R. Shapiro	
22d. ADDRESS 8218 Wisc. Ave. N.W. Wash. DC.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Removal	8-28-1967	Baltimore Nat'l. Cem.	Baltimore, Md.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. REC'D BY REGISTRAR SEP 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
5130 Wisc. Ave. N.W. Wash. D.C.					



38

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/67

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE N.Y. b. COUNTY WUTHERBOROUGH	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springdale Rd. Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		e. STREET ADDRESS 8505 Springdale Rd. Silver Spring	
3. NAME OF DECEASED (Type or print) Margaret First Margaret Middle NMN Last Heberton		DATE OF DEATH Month August Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Scotland	
13. FATHER'S NAME George Millar		12. CITIZEN OF WHAT COUNTRY? Amer.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT Address HOSPITAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 472 X IMMEDIATE CAUSE (a) Acute, bilateral, pneumonitis; DUE TO (b) Anemia; Arteriosclerotic heart disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Peare M.D.		22. DATE SIGNED August 29, 1967	
EXAMINER'S NAME (Type) BELDEN R. PEARE M.D.		23. ADDRESS (City or town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) 8-17-67		23b. DATE THEREOF 8-17-67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or town) (County) (State) Fort Myer VA	
24. FUNERAL DIRECTOR Domino Funeral Home		25a. REC'D BY REG. STRAR DATE AUG 23 1967	
25b. REG. STRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

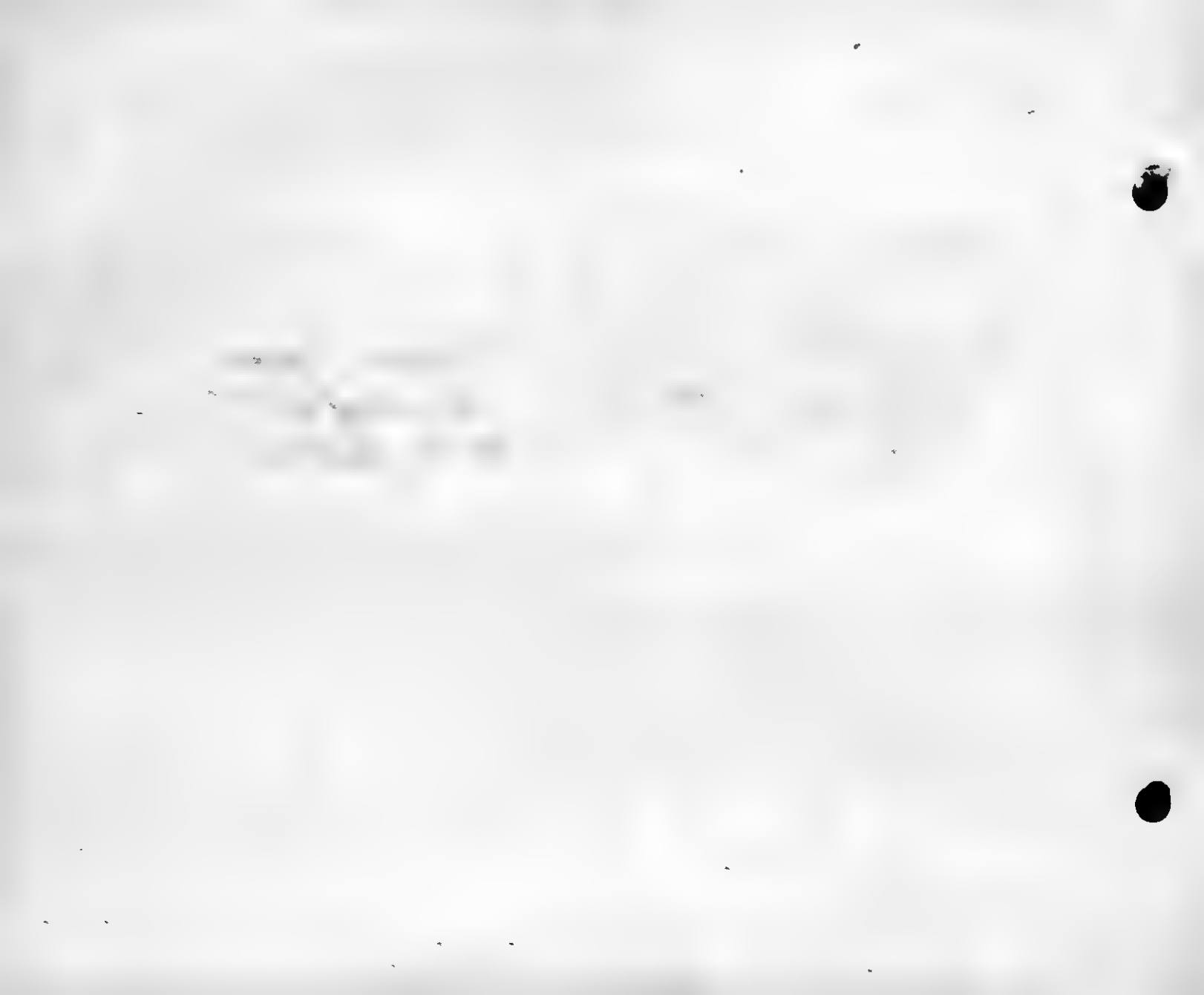
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3013 Jennings Road</u>	
3. NAME OF DECEASED (Type or print) First <u>ERNA</u> Middle <u>XX</u> Last <u>HECK</u>		4 DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-2-65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DEACONESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethesda Home Lutheran</u>	9. AGE (In years last birthday) <u>62</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>New York, U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Stephen Heck</u>		14 MOTHER'S MAIDEN NAME <u>Emile Lettbarne</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO. <u>YES</u>	
17 INFORMANT <u>Albert Heck</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>15 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>67</u> , to <u>8/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/19</u> , 19 <u>67</u> , and that death occurred at <u>4:30 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Fred A. Gill</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Fred A. Gill</u>		22d. ADDRESS <u>4743 Bondley Blvd, Chingwood</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>August 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. IF FUNERAL DIRECTOR: <u>John B. Thomas</u> <u>Warner E. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>John B. Thomas</u> 25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>	
25c. DATE <u>AUG 25 1967</u>		25d. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>	



cleared with medical examiner
Dr. Reap.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11199

CERTIFICATE OF DEATH

11200

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 2 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Randolph Hills Nursing Home		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MONTGOMERY b. COUNTY Wheaton Maryland MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton d. STREET ADDRESS 12307 Good Hill RD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY Louise HEFLIN		4. DATE OF DEATH Month Day Year August 19 1967	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-23-1890
9 AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Augustus Neitzow		14. MOTHER'S MAIDEN NAME Mary Bernhardt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Curtis A. Heflin		Address 6302 - 94th Avenue Seabrook, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY 4131 IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized And Cerebral Arteriosclerosis, Fractured Hip			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell at home going from Chair To bed	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3 p.m. 5/10 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, offce bldg, etc) Home	20f. (City or town) (County) (State) Wheaton Mont. Md.
21. I certify that (I) (this hospital) attended the deceased from 5/11 , 19 67 to 8/19 , 19 67 , that (I) (we) lost the deceased alive on 8/19 19 67 , and that death occurred at 6:45 PM , from causes on and on the date stated above.			
22a. SIGNATURE Raymond T. Benack MD		22b. DATE SIGNED 8/19/67	
22c. PHYSICIAN'S NAME (Type) Raymond T. Benack MD		22d. ADDRESS 4115 Colie Dr, Wheaton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Maryland
24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc. Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge

DATE AUG 24 1967

will, brace

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11200

11201

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if it institut an Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c LENGTH OF STAY IN 15 <u>TAKOMA PARK</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN + Hosp.</u>		d STREET ADDRESS <u>8203 Harland Ave #2</u>	
3 NAME OF DECEASED (Type or print) <u>LUCILLE DENA HEINE</u>		4 DATE OF DEATH <u>8 20 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-13-10</u>
9 AGE (In years last birthday) <u>57</u> yrs		10 IF UNDER 1 YEAR <u>20</u> Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>ILL.</u>	
11 BIRTHPLACE (State or foreign country) <u>USA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>MARCEL BERTRAND</u>		14 MOTHER'S MAIDEN NAME <u>BELANGER</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>HUSBAND</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>lost.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Indetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>8/20/1967</u>	
EXAMINER'S NAME (Type) <u>BELOEN R. REAP</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town or County)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>Aug 24, 1967</u>	23c NAME OF CEMETERY OR CRAMATORY <u>Calvary Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Denton, Md.</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a REC'D BY REGISTRAR <u>254 Carroll St</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 22 1967</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11202

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY (In days) 3 weeks 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton d. STREET ADDRESS 3126 Helsel Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) James Earl Helsel, Sr.		4. DATE OF DEATH Month August Day 7 Year 1967	
5 SEX Male	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 24, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mig's representative		10b. KIND OF BUSINESS OR INDUSTRY Govt. Sales	9 AGE (In years last birthday) 66 yrs
11 BIRTHPLACE (County & State, or foreign country) Pennsylvania; Blair Co.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Helsel		14. MOTHER'S MAIDEN NAME Clara Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 579-22-8487	
17. INFORMANT Carl Helsel, Jr.		18. ADDRESS 3109 Helsel Dr., Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO (b) broncho pneumonia DUE TO (c) hypertensive Cardiovascular Disease			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) hypertensive Cardiovascular Disease			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/15 1967 to 8/7 1967 , that (I) (we) lost saw the deceased alive on 8/7 1967 and that death occurred at 8:00 P.M. from causes and on the date stated above			
22a. SIGNATURE Myron L. Lenkin		22b. DATE SIGNED 8/8/67	
22c. PHYSICIAN'S NAME (Type) Myron L. Lenkin, M.D.		22d. ADDRESS 2309 Shorefield Rd., Wheaton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR C. Glen Carter		25a. RECD BY REGISTRAR AUG 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 434 Georgia Avenue	
25d. Warner E. Pumphrey, Inc.		25e. Silver Spring, Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11262

CERTIFICATE OF DEATH

11203

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE California b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b Del Mar			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home				d. STREET ADDRESS 1266 Cuchare Drive			
3. NAME OF DECEASED (Type or print) Catherine S. Henderson				4. DATE OF DEATH August 10 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1885		9. AGE (In years last birthday) 82 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Sciple				14. MOTHER'S MAIDEN NAME Reese			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO 144-01-2770		17. INFORMANT 1153 Randolph Rd. Marguerite H. Peppin McLean, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Cerebrovascular thrombosis (multiple) DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 days 5 yrs 10 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/25/67 , 19 67 , to 8/9/67 , 19 67 , that (I) (we) last saw the deceased alive on 8/7/67 , 19 67 , and that death occurred at 1:55 p.m. from causes and on the date stated above.							
22a. SIGNATURE Henry C. Scruggs				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8/10/67	
22c. PHYSICIAN'S NAME (Type) Henry C. Scruggs				22d. ADDRESS 5413 Cedar Lane-Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/12/67		23c. NAME OF CEMETERY OR CREMATORY West Laurel Hill		23d. LOCATION (City or Town) (County) (State) Philadelphia. Pa.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.				25a. REC'D BY REGISTRAR DATE AUG 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

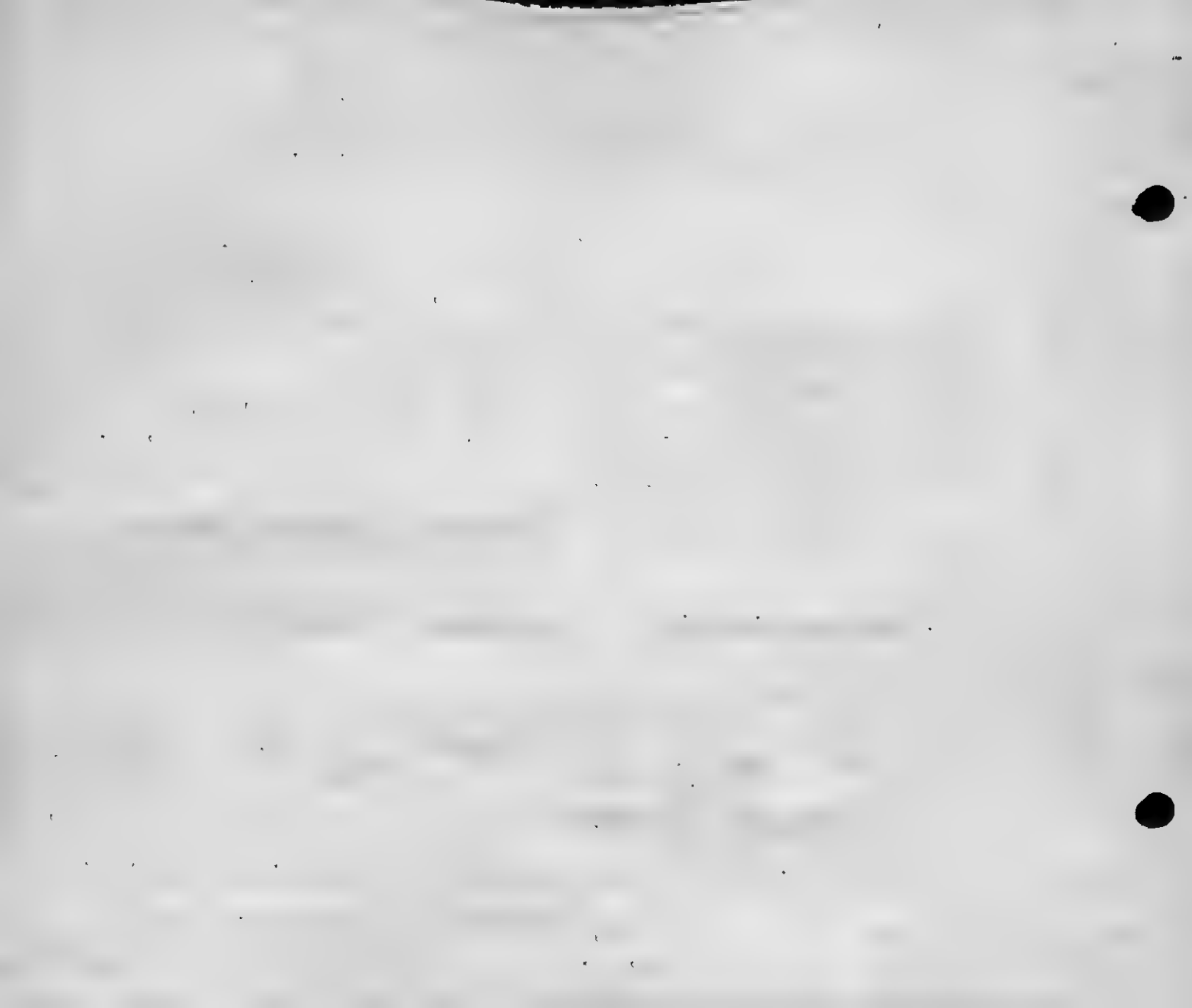
11204

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>10100 Gates Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Hensley</u>		4. DATE OF DEATH <u>August 31 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/18/98</u>
9. AGE (In years, last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Brownlow Hensley</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWI Army</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of the Vertebrae</u> 165X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of the Lung</u> DUE TO (c) <u>with metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pseudohyperparathyroidism due to Cancer.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-3</u> , 19 <u>67</u> , to <u>8-31</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/31</u> 19 <u>67</u> , and that death occurred at <u>4:40</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Alan R Gair</u>		22b. DATE SIGNED <u>8/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALAN R Gair MD</u>		22d. ADDRESS <u>7777 Maple Ave Takoma Park MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL & REM</u>	23b. DATE THEREOF <u>AUG 31 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BIG STONE CEM.</u>	23d. LOCATION (City or town) (County) (State) <u>BIG STONE GAP VA.</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS</u>		25a. REC'D BY REGISTRAR <u>1400 CHAPIN ST. NW WASHINGTON, D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>W.W. Chambers</u>		DATE <u>SEP 6 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 5-63

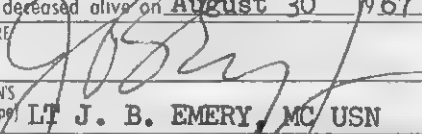
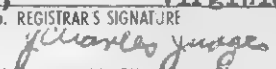
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11204 CERTIFICATE OF DEATH 11205											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN TB 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md. d. STREET ADDRESS 311 Laura Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Arthur J. Hergenroeder First Middle Last						4. DATE OF DEATH Aug 6 1967 Month Day Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1906		9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesale Plumbing						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Hergenroeder						14. MOTHER'S MAIDEN NAME Julia Flaherty					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WW 11						16. SOCIAL SECURITY NO. 214-03-1224		17. INFORMANT Mary E. Hergenroeder		Address 311 Laura Lane Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia											
DUE TO Chronic Glomerulonephritis (Probable)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - Pulmonary Tuberculosis											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 1967 to Aug 1967 , that (I) also saw the deceased alive on Aug 5 1967 , and that death occurred at 4:50 A from the causes and on the date stated above											
22a. SIGNATURE James W. Egan						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE August 6, 1967		SIGNATURE	
22c. PHYSICIAN'S NAME (Type) James W. Egan						22d. ADDRESS 11900 Smoketree Rd. Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/9/67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler				1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR AUG 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital						d. STREET ADDRESS 4608 Chevy Chase Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Joseph Last HICKEY						4. DATE DEATH Month AUGUST Day 30 Year 19 67					
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7, 1902		9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 30 Days 19 Hours 67 Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (County & State, or foreign country) St. Louis, Missouri				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeremiah Hickey						14. MOTHER'S MAIDEN NAME Ann Lawton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1925-1948				16. SOCIAL SECURITY NO. 489 34 4666		17. INFORMANT Chevy Chase Address Maryland Mrs. Helen W. Hickey, 4608 Chevy Chase Blvd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Interstitial Pulmonary Fibrosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (a) (this hospital) attended the deceased from August 28 , 19 67 , to August 30 , 19 67 , that (x) (we) last saw the deceased alive on August 30 , 19 67 , and that death occurred at 2:00A M, from causes and on the date stated above											
22a. SIGNATURE 						M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22b. DATE SIGNED August 30, 1967			
22c. PHYSICIAN'S NAME (Type) LT J. B. EMERY, MC USN						22d. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-1-1967		23c. NAME OF CEMETERY OR CREMATORY Arlington, National				23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Joseph Gawler & Sons ADDRESS 5130 Wisconsin Ave., N.W. Washington, D.C.						25a. REC'D BY REGISTRAR DATE SEP 5 1967		25b. REGISTRAR'S SIGNATURE 			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11206

11207

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Olney		c. LENGTH OF STAY IN 1b SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL D.O.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First WAYNE Middle ELBERT Last HOLLAND		4 DATE OF DEATH Month 8 Day 17 Year 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/18/60
9 AGE (In years lost birthday) yrs 7		10 IF UNDER 1 YEAR Months 1 Days 17 Hours 17 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) YORK, PENNSYLVANIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME ALVIN J. HOLLAND		14 MOTHER'S MAIDEN NAME MELVINA RAFFENBERGER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO NONE	
17 INFORMANT SISTER AND MOTHER		Address SAME	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Extreme Injuries DUE TO (b) including fractured Skull DUE TO (c) due to auto striking deceased.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8.) Deceased ran into street and was struck by passing car in front of home.	
20c. TIME OF INJURY Month, Day, Year 3-8-17 1967		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street Silver Spring Montgomery Md.		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/21/67	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1351 Rockville Pike Rockville, Maryland		25a. REC'D BY REGISTRAR DATE AUG 21 1967	
25b. REGISTRAR'S SIGNATURE James J. Judge		22. DATE SIGNED 8/17/1967	

4 1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11208
CERTIFICATE OF DEATH

11208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>324 Lincoln Ave., Rockville</u>	
c. LENGTH OF STAY IN 1b. <u>50.00</u>		d. STREET ADDRESS <u>324 Lincoln Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Mary L. Howard</u>		4 DATE OF DEATH <u>8-6-67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1902</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James S. Cole</u>		14. MOTHER'S MAIDEN NAME <u>Lila Gant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Husband - Frederick - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Arteriosclerotic C-V Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 years</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A T.O.P.S.Y. PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. ((City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> 19 <u>57</u> to <u>Aug 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 8</u> 19 <u>67</u> , and that death occurred at <u>263</u> M., from causes and on the date stated above			
22a. SIGNATURE <u>Clive E. Jackson, M.D.</u>		22b. DATE SIGNED <u>8-6-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8-9-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montg. Co., Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowdon</u>		25a. REC'D BY REGISTRAR <u>AUG 8 1967</u> REGISTRAR'S SIGNATURE <u>Judge</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

11209

11209

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c LENGTH OF STAY IN b <u>1 hr. 24 1/2 mid.</u>	c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		e STREET ADDRESS <u>9415 Crosby Rd.</u>	f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <u>Edward Joseph Hoy, Jr.</u>		4 DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/29/24</u>
9 AGE (In years last birthday) <u>43</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11 IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	11 BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Edward J. Hoy</u>	
14 MOTHER'S MAIDEN NAME <u>Katherine Woersdorfer</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes World War II</u>	
16 SOC. A. SECURITY NO. <u>220-12-2520</u>		17 INFORMANT <u>Olney, Md.</u> Address <u>Medical Records of Montg. General Hospt.</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration, Gastric Content</u> 581.1 DUE TO (b) <u>Hemorrhage, esophageal varices, massive</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost <u>Alcoholism, Chronic</u> DUE TO (c) <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fatty metamorphosis, Liver</u>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquest <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>8/30/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		Address (Street, city, town or county) <u> </u>	
23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>September 2, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24 FUNERAL DIRECTOR <u>Thomas J. Warner & Son</u>		25a REC'D BY REGISTRAR <u>SEP 5 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>

hand

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11203

CERTIFICATE OF DEATH

1-2-0

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>3 1/2 hrs</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>929 Maple Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lucy M. Zuhler</u> First Middle Last				4. DATE OF DEATH <u>8</u> Month <u>26</u> Day <u>19</u> Year <u>67</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-23-10</u>	
9. AGE (In years lost b r/h/day) <u>57</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Safeway Store</u>		11. BIRTHPLACE (County & State or foreign country) <u>West Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Lenie Ritchie</u>		14. MOTHER'S MAIDEN NAME <u>Mary Susan Ratlieff</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>213-38-2684</u>		17. INFORMANT <u>Larry D. Huddle</u>		Address <u>Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adeno carcinoma of the ovary</u> DUE TO (b) <u>with extensive metastases</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 5, 1967</u> to <u>Aug. 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug. 26, 1967</u> , and that death occurred at <u>5 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>G. Bowditch Hunter, Jr.</u> M.D.				22b. DATE SIGNED <u>Aug. 26, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter, Jr.</u>	
22d. ADDRESS <u>Rockville, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 30, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>		23d. LOCATION (City or Town) (County) (State) <u>Damascus, Md.</u>	
24. FUNERAL DIRECTOR <u>Olin L. Molesworth,</u> ADDRESS <u>Damascus, Md.</u>				25a. REC'D BY REGISTRAR <u>AUG 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

July 2014

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>DOA</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Sabina Johanna Hyatt</u>		4 DATE OF DEATH Month <u>Aug</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>Fe</u>		6 COLOR OR RACE <u>W.</u>	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Jan 16 1965</u>	
9 AGE (In years last birthday) <u>2 1/2</u> yrs		10 IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		12 KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13 FATHER'S NAME <u>Quentin Hyatt</u>		14 MOTHER'S MAIDEN NAME <u>Henriette Droste</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Father James</u>		Address <u>2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination from Laceration of Neck</u> DUE TO (b) <u>Trauma of Auto Accident</u> DUE TO (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) <u>Thrown through wind shield when car crossed car in front.</u>	
20c TIME OF INJURY Month Day Year <u>10:00 8/8 1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e PLACE OF INJURY (Home farm factory, street, office bldg, etc) <u>Street</u>		20f (City or town) (County) (State) <u>Rockville Mont. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/8/67</u>	
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		23. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/8/67</u>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
23e FUNERAL DIRECTOR		23f REG'D BY REGISTRAR	
23g REG'D BY REGISTRAR		23h REG'D BY REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE NEW YORK b. COUNTY WESTCHESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Vernon	
3. NAME OF DECEASED (Type or print) SOPHIE First NMN Middle HYMOWITZ Last		4. DATE OF DEATH Month August Day 22 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 77 yrs
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL Steinberg		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 070-207752	
17. INFORMANT Hospital Records		Address 7600 Carroll Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Gall Bladder with Hepatic metastases DUE TO (b) metastases DUE TO (c) Carcinoma of Gall Bladder + cholangitis			INTERVAL BETWEEN ONSET AND DEATH about 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour pm 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/2 , 19 67 , to 8/22 , 19 67 that (I) (we) last saw the deceased alive on 8/21 , 19 67 , and that death occurred at 6:30 PM , from causes on and on the date stated above.			
22a. SIGNATURE Benjamin Isaacson		22b. DATE SIGNED 8/22/67	
22c. PHYSICIAN'S NAME (Type) Benjamin Isaacson		22d. ADDRESS 7733 Alaska Ave. N.W. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-23-1967	23c. NAME OF CEMETERY OR CREMATORY National Memorial Park	23d. LOCATION (City or Town) (County) (State) Falls Church Va.
24. FUNERAL DIRECTOR Goldberg Funeral Home		25a. REC'D BY REGISTRAR DATE AUG 25 1967	
ADDRESS 4217 9th St., N.W.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



11212

CERTIFICATE OF DEATH

11213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John		c. LENGTH OF STAY IN 1b Cabin John	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7629 Cabin Road		d. STREET ADDRESS 7629 Cabin Road	
3. NAME OF DECEASED (Type or print) First DONALD Middle HUNT Last IGLEHART		4. DATE OF DEATH Month AUGUST Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/03
9. AGE (In years lost birthday) yrs. 63		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY Architectural	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas G. Iglehart		14. MOTHER'S MAIDEN NAME Olga Ulrich	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-40-9994	
17. INFORMANT Mrs. Frances L. Iglehart, Wife		Address Same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO (b) MYOCARD. INFARCTION DUE TO (c) CORONARY ARTERY SCLEROSIS			
INTERVAL BETWEEN ONSET AND DEATH 5 min 15 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) (8-H-67)	
21. I certify that (1) (this hospital) attended the deceased from 1952 , 19 DATE , 19 DATE , to DATE , 19 DATE , that (1) (we) last saw the deceased alive on 10 AUG 19 67 , and that death occurred at 8 A M, from causes and on the date stated above.			
22a. SIGNATURE Charles W. Thompson		22b. DATE SIGNED 14 Aug 67	
22c. PHYSICIAN'S NAME (Type) DR. CHARLES W. THOMPSON		22d. ADDRESS 703 24th. St. N.W. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/16/67	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Wash., D. C.		25a. REC'D BY REG STRAR AUG 17 1967	
25b. REG. STRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

County of Health Prior to Burial, Cremation, or Removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11213

CERTIFICATE OF DEATH

11214

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b COUNTY Carroll	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Md		c. LENGTH OF STAY IN 1b 1 day	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d STREET ADDRESS Box 244 Rt#1	
3 NAME OF DECEASED (Type or print) Bessie B Jenkins		4 DATE OF DEATH Month 8 Day 1 Year 19 67	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) 72 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Sam Ridgely		14 MOTHER'S MAIDEN NAME Maryann Hughes	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO -	
17. INFORMANT Hospital Records		Address	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MASSIVE MYOCARDIAL INFARCT DUE TO CONGESTIVE HEART FAILURE DUE TO ATHEROSCLEROTIC C.V. DISEASE INTERVAL BETWEEN ONSET AND DEATH 6 hrs. Yes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS : OBESITY			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item #B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 7-31-67 , 19__, to 8-1-67 , 19__, that (I) (we) last saw the deceased alive on 8-1-67 , 19__, and that death occurred at 6:22AM , from causes and on the date stated above			
22a SIGNATURE Donald P. Lewis		22b DATE SIGNED Aug 2, 67.	
22c PHYSICIAN'S NAME (Type) Donald P. Lewis		22d ADDRESS Montgomery Gen Hospital	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF 8-4-67	23c NAME OF CEMETERY OR CREMATORY LAKE VIEW	23d LOCATION (City or Town) (County) (State) Sykesville Md.
24 FUNERAL DIRECTOR Harry W. Haight		25a REC'D BY REGISTRAR OATE AUG 8 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
20 M 1/66

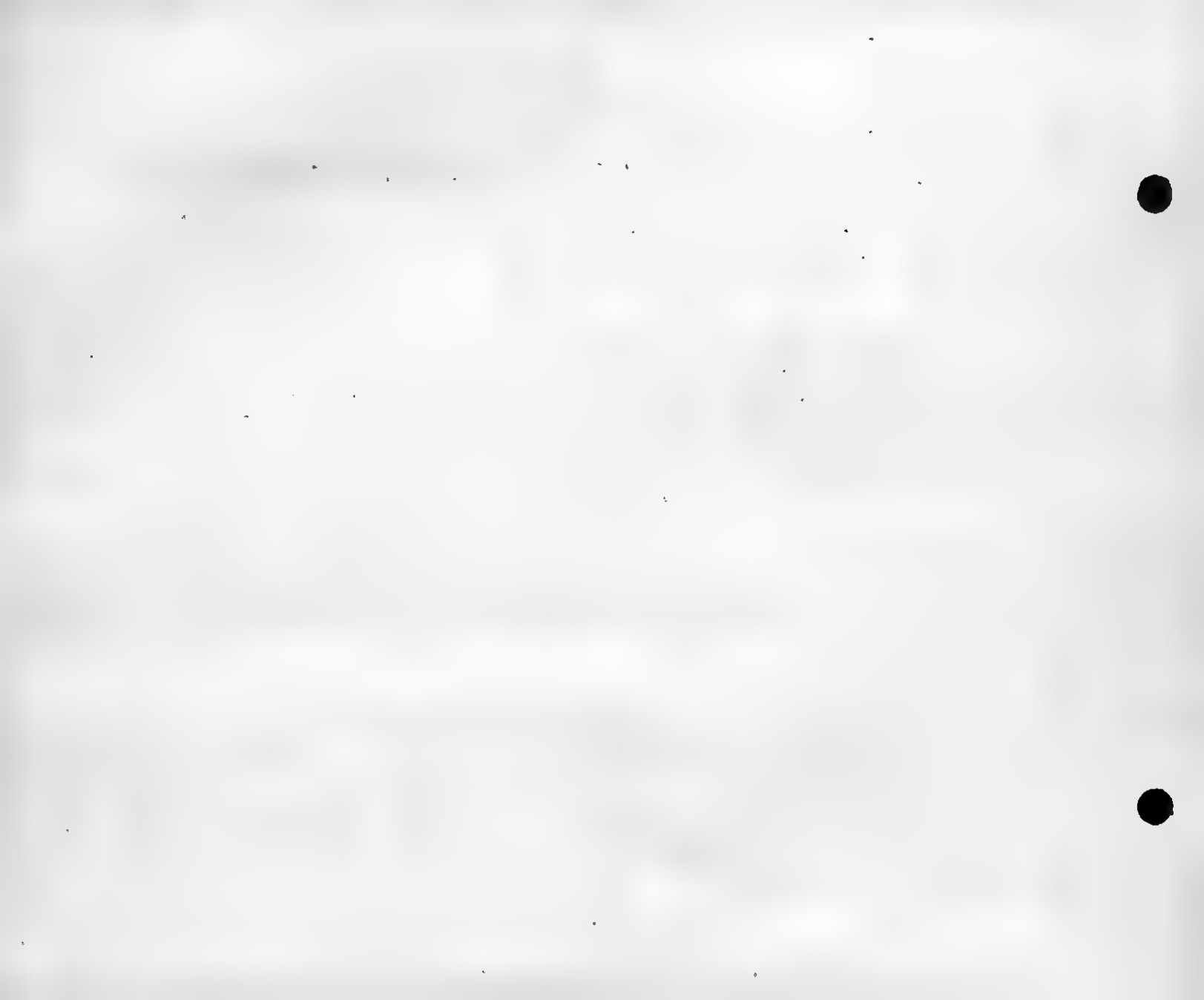
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11214

CERTIFICATE OF DEATH

11215

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> M.D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FAIRLAND NURSING Home</u>				d. STREET ADDRESS <u>8625 Piney Branch Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JENNIE K JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>8 / 23 / 1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/21/94</u>		9. AGE (In years last birthday) yrs <u>73</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS KEELY</u>				14. MOTHER'S MAIDEN NAME <u>ELANORE JARVIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>578-44-3191B</u>		17. INFORMANT Address <u>Nursing Home Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Arteriosclerotic Cerebrovascular Disease</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10+ yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>Aug 23</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Aug 22 1967</u> , and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John F. Gustafson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>23 Aug. 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John F. Gustafson</u>				22d. ADDRESS <u>915 19th Street, N.W. Wash., D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery, Prince Georges County,</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> <u>2901 14th St. N.W. Washington, D.C.</u>				25a. REC'D BY REGISTRAR <u>AUG 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11215

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>8402 26th Place</u>	
3. NAME OF DECEASED (Type or print) <u>Jonnie Lofton Johnson</u>		4. DATE OF DEATH Month <u>8</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-21-04</u>
9. AGE (In years lost birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tom Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Sillie Korranger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>223-14-1216</u>	
17. INFORMANT <u>Ruth L. Johnson, Adelphi Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> + <u>LOI</u> DUE TO Conditions if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Coronary Artery Heart Disease</u> (c) <u> </u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 7, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 8 1967</u>	
25b. REC'D BY S.S. SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>Aug. 3, 1967</u>	

11216

CERTIFICATE OF DEATH

2-2-67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Washington, DC		b. COUNTY NE (section)	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c LENGTH OF STAY IN 1b 3 1/2 mos.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5024 Eastern Ave., NE			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				d. STREET ADDRESS as above		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Susan Ellen Johnson				4. DATE OF DEATH 8/13/1967		Month Day Year 19	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1889		9 AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic work		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Struthers, Ohio		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar Thomas				14 MOTHER'S MAIDEN NAME Hattie			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 235-80-3255		17. INFORMANT Address Washington, DC Mrs. Harriet Wood-5024 Eastern Ave., NE.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 157A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Adenocarcinoma, Rectum</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 12, 1967</u> to <u>Aug 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 15, 1967</u> , and that death occurred at <u>8:14 A.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>Kevin H. Flung</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED 8-13-67			
22c. PHYSICIAN'S NAME (Type) Dr. J. Kurtz		22d ADDRESS 2202 Georgia Ave., NW, Washington, DC					
23a BURIAL, CREMATION, REMOVAL (Type) Burial		23b DATE THEREOF Aug. 19, 1967		23c NAME OF CEMETERY OR CREMATORY Church Cemetery		23d. LOCATION (City or Town) (County) (State) Youngstown, Ohio	
24 FUNERAL DIRECTOR <u>Senior Funeral Home</u>		ADDRESS 3015 12th St., Washington, D.C.		25a. REC'D BY REGISTRAR DATE <u>AUG 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

11217

Item #12 Filed #733-1/1/67

2 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN TB <u>8 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2002 14th Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8508 - 16th St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jacob</u> First <u>Kagan</u> Middle <u>Kagan</u> Last 4. DATE OF DEATH <u>8</u> Month <u>11</u> Day <u>1967</u> Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 19, 1890</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Hyman Kagan</u>		14. MOTHER'S MAIDEN NAME <u>Chara</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war and dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mollie Kagan, wife - Same</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-19</u> to <u>8-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-10</u> , 19 <u>67</u> , and that death occurred at <u>10:55 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Morton Altschuler</u> M.D.		22b. DATE SIGNED <u>8-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morton Altschuler, M.D.</u>		22d. ADDRESS <u>9205 New Hampshire Ave Silver Spring, Md</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/13/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden Falls Church, Va.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Augausky</u> ADDRESS <u>3301-14 St NW Wash D.C.</u>		25a. REC'D BY REGISTRAR <u>DAUG 15 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11218

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN TB <u>ROCKVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>4004 BLACKPOOL RD.</u>	
3. NAME OF DECEASED (Type or print) <u>MINNIE KAUFMAN</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15 1907</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ZEV DANICK</u>		14. MOTHER'S MAIDEN NAME <u>CHAVA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>DAUGHTER</u> Address <u>ROCKVILLE MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Intractable Congestive Heart Failure - Pulm Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
DUE TO (b) <u>atherosclerotic coronary thrombosis, recurrent</u>		DUE TO (c) <u>—</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - severe</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1</u> , 1966, to <u>August 1</u> , 1967, that (I) (we) last saw the deceased alive on <u>Aug 1</u> , 1967, and that death occurred at <u>2:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>8-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE U. CLHEN M.D.</u>		22d. ADDRESS <u>1106 SPRING SILVER SPRING ST MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-3-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WORKMEN'S CIRCLE CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS</u> ADDRESS <u>WASHINGTON DC</u>		25a. REC'D BY REGISTRAR <u>Charles J. [Signature]</u> DATE <u>AUG 4 1967</u>	

11218

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED BY MEDICAL EXAMINER

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. LENGTH OF STAY IN 1b <u>WHEATON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>2212 PRICHARD</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>ALFRED S. KAY</u>		4 DATE OF DEATH Month Day Year <u>8 27 19 67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>CAUC.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-20-93</u>
9. AGE (In years last b. day) <u>74</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>RETIRED Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MORRIS KAY</u>		14. MOTHER'S MAIDEN NAME <u>ANNA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>188-01-3314</u>	
17 INFORMANT <u>EDWIN KAY</u>		Address <u>9925 GA AVE. SSF MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute left ventricular failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>arteriosclerotic heart disease</u> (b) <u>arteriosclerotic heart disease</u> (c) <u>arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3-4 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral thrombosis & embolism</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>65</u> , to <u>8-27, 1967</u> , that (I) (we) last saw the deceased alive on <u>8-27</u> , 19 <u>67</u> and that death occurred at <u>10:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Jason Geiger</u>		22b. DATE SIGNED <u>8-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JASON GEIGER, M.D.</u>		22d. ADDRESS <u>800 PERSHING DRIVE SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u>		23d. LOCATION (City or town) (County) (State) <u>FALLS CHURCH, VA.</u>	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 1 1967</u>	
ADDRESS <u>4217 5th St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11221

11220

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sutton	
c. LENGTH OF STAY IN TB 10 days		d. STREET ADDRESS Box 144 Herold Route	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jeffrey Dean KEENER		4. DATE OF DEATH Month Day Year August 25 19 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1960
9. AGE (in years last birthday) 7 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Wurtsmith, Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George D. Keener		14. MOTHER'S MAIDEN NAME Emma Jean Rose	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N.A.		16. SOCIAL SECURITY NO.	
17. INFORMANT Sutton, W. Va.		Address Mr. George D. Keener, Box 144 Herold Route	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from August 15, 19 67 , to August 25 19 67 that (he) (we) lost the deceased alive on August 25 19 67 , and that death occurred at 500A M, from causes on and on the date stated above.			
22a. SIGNATURE P. AH-TYE		22b. DATE SIGNED Aug. 25., 1967	
22c. PHYSICIAN'S NAME (Type) P. AH-TYE		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8-26-67	23c. NAME OF CEMETERY OR CREMATORY Family Cemetery	23d. LOCATION (City or town) (County) (State) Sutton, West Virginia
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR AUG 28 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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112221

CERTIFICATE OF DEATH

11222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>md.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>2230 Washington Ave. Silver Spring</i>		d. STREET ADDRESS <i>2230 Washington Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Russell</i> Middle <i>Garland</i> Last <i>Kelly</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>17</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 26, 1903</i>
9. AGE (In years last birthday) <i>63 yrs</i>		F UNDER 1 YEAR IF UNDER 24 MRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Church Sexton</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Richmond, Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Robert Henry Kelly</i>		14. MOTHER'S MAIDEN NAME <i>Louella Crowder</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>223-05-7089</i>	
17. INFORMANT <i>Wife</i>		Address <i>2230 Wash. Ave. Silver Spring Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <i>1911 Metastatic Carcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Primary Site unknown</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>March 20, 1967</i> , to <i>Aug 17, 1967</i> , that (I) (we) last saw the deceased alive on <i>Aug 17, 1967</i> , and that death occurred at <i>6:15 P.M.</i> from causes and on the date stated above			
22a. SIGNATURE <i>Neil P. Campbell</i>		22b. DATE SIGNED <i>8/17/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Neil P. Campbell</i>		22d. ADDRESS <i>1629 Col. Rd.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 22, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mauzy Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Richmond Virginia</i>	
24. FUNERAL DIRECTOR <i>Arthur Walters, 254 Carroll St N.W. D.C.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>AUG 22 1967</i>	

41
FOR STATE
HEALTH DEPT.

11222

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11223

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY HOWARD	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d STREET ADDRESS CLARKSVILLE	
3 NAME OF DECEASED (Type or print) Charles Nicholson Kendall		4 DATE OF DEATH Month 8 Day 13 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/21/01
9 AGE (In years last birthday) 65 yrs.		10 IF UNDER 1 YEAR Months 13 Days 19 Hours 67 Min	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retailer		11b KIND OF BUSINESS OR INDUSTRY General Store	
12 CITIZEN OF WHAT COUNTRY? Ithica, Ny		13 BIRTHPLACE (State or foreign country) Ithica, Ny	
14 FATHER'S NAME Franklin Kendall		15 MOTHER'S MAIDEN NAME Mabel Crawford	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 212-34-3911		17 INFORMANT (wife) Address Mary P. Kendall Clarksville, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) due to Occlusion of Circumflex DUE TO (c) Coronary Artery; Arteriosclerotic Heart Dis.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF DEATH Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF	
Burial		Aug. 17, 1967	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)	
St. Marks		Highland, Md	
24 SIGNATURE OF DIRECTOR John R. Slack		25a REC'D BY REGISTRAR	
Highbotham-Slack, Ellicott City, Md		25b REGISTRAR'S SIGNATURE	
DATE AUG 16 1967		John R. Slack	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11223

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY IN 1b <u>29 YRS.</u>		d. STREET ADDRESS <u>6609 RIVER ROAD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6609 RIVER ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLARD</u> <u>MONROE</u> <u>KIPLINGER</u>		4. DATE OF DEATH Month Day Year <u>AUGUST</u> <u>6</u> <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 8, 1891</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EDITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLISHING</u>	
11. BIRTHPLACE (State or foreign country) <u>BELLEFONTAINE OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLARENCE E. KIPLINGER</u>		14. MOTHER'S MAIDEN NAME <u>CORA MILLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>597033771</u>	
17. INFORMANT (SON) <u>AUSTIN KIPLINGER</u>		Address <u>POOLESVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 19, 1967</u> to <u>AUGUST 6, 1967</u> , that I last saw the deceased alive on <u>AUGUST 6, 1967</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. Ecker</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>9/6-19/67 ST. N. W., WASHINGTON DC 8/6/67</u>	
PHYSICIAN'S NAME (Type) <u>HENRY D. ECKER M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION Aug 7, 1967</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill CEMETORY</u>		22d. LOCATION (City, town, or county) (State) <u>SWITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Son's Inc. Washington, D.C.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>AUG 8 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11225

11224

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		c. LENGTH OF STAY IN 1b <u>17 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Cornelis Robert KNEPPELHOUT de STERKENBURG</u>				4 DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1967</u>			
5 SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-1883</u>		9 AGE (In years last birthday) <u>84 yrs</u>	IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer, Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>DOORN NETHERLANDS</u>		12. CITIZEN OF WHAT COUNTRY? <u>NETHERLANDS</u>	
13. FATHER'S NAME <u>CORNELIS J. KNEPPELHOUT VAN STERKENBURG</u>				14. MOTHER'S MAIDEN NAME <u>CORNELIA SCHUURBEKE BOYE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-34-3595</u>		17. INFORMANT <u>Marie Renée de Sterkenburg - Poolesville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>610A</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Benign Prostatic Hypertrophy</u> DUE TO (c) <u>5 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus ulcers</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> to <u>Aug 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>11 Aug 1967</u> , and that death occurred at <u>24 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>John S. Lawatt</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		23d. LOCATION (City or town) (County) (State) <u>Barnesville Montg. Md</u>	
24. FUNERAL DIRECTOR <u>Hilton Funeral Home</u>		ADDRESS <u>Barnesville Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>AUG 21 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11225

CERTIFICATE OF DEATH

11226

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>7501 DEMOCRACY BLVD.</u>	
3 NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>L</u> Last <u>KNOWLES</u>		4 DATE OF DEATH Month <u>Aug</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-1948</u>
9a. US. JAIL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>19</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>Cincinnati OHIO</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANCIS W. LEONARD</u>		14. MOTHER'S MAIDEN NAME <u>Constance Yeates</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>ALBERT S Knowles</u> (husband) Address <u>(SAME AS ABOVE)</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Carcinomatosis - right ovary (primary)</u> DUE TO (c) <u>(Papillary serous cystadenocarcinoma)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tumor perforation of ileum with loculated purulent peritonitis.</u>			19 WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-22-</u> , 19 <u>66</u> , to <u>8-13-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-13-</u> , 19 <u>67</u> , and that death occurred at <u>5:15 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Ronald Barr</u>		22b. DATE SIGNED <u>8/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RONALD BARR</u>		22d. ADDRESS <u>10401 Old Georgetown Rd. Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Cremation</u>	<u>8-15-67</u>	<u>Ft. Lincoln Crematory</u>	<u>Prince George County, Md</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
		DATE <u>AUG 21 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



11226

CERTIFICATE OF DEATH

11227

1. PLACE OF DEATH a. COUNTY <u>ONTODDERY, CT.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>NTODDY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS Hosp.</u>		d. STREET ADDRESS <u>1401 Blair Hall Rd.</u>	
3. NAME OF DECEASED (Type or print) First: <u>MAX</u> Middle: <u>KOHRN</u> Last: <u>KOHRN</u>		4. DATE OF DEATH Month: <u>AUG</u> Day: <u>25</u> Year: <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-02-1893</u>
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months: <u>1</u> Days: <u>25</u> Hours: <u>15</u> Min: <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst P.M. Gen. Fed.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Kohrn</u>		14. MOTHER'S MAIDEN NAME <u>Sheindel Sternlicht</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>267-466149</u>	
17. INFORMANT <u>Hosp. Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> DUE TO <u>Cirrhosis Liver - Post-Necrotic</u> (b) <u>HEPATITIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>7 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> Month, Day, Year p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>66</u> to <u>8-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 25</u> 19 <u>67</u> , and that death occurred at <u>8:27</u> M, from causes on and the date stated above.			
22a. SIGNATURE <u>Robert Kramer</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert Kramer, M.D.</u>		22d. ADDRESS <u>8484 16th St - 88 Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-28-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Falls Church Va.</u>	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Aug 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

11227

11228

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>MONTGOMERY</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c LENGTH OF STAY IN 1b <u>3yrs 3 month</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens SANITORIUM</u>				d STREET ADDRESS <u>10009 Grayson Ave.</u>			
3 NAME OF DECEASED (Type or print) <u>Demeter</u> First Middle Last <u>KONSTANTINOFF</u>				DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>77yrs</u>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT OWNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Greece</u>	
13. FATHER'S NAME <u>Unknown</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>				16 SOCIAL SECURITY NO <u>299-30-1293A</u>		17. INFORMANT <u>Karl D. Kostoff</u> Address <u>10009 Grayson Avenue Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>77</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>Indur</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis; cerebral thrombosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u>63</u> , to <u>August 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 16</u> 19 <u>67</u> , and that death occurred at <u>235</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>Bennet A. Porter Jr.</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>August 4, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>				22d. ADDRESS <u>9301 Colesville Rd, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Aug 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas & Son 434 Georgia Avenue Warner E. Humphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CLERK WITH MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>					c. LENGTH OF STAY IN 1b <i>2 yrs.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>8303 Springdale Road</i>					d. STREET ADDRESS <i>8303 Springdale Road</i>					
3. NAME OF DECEASED (Type or print) <i>George R La Rue</i>					4. DATE OF DEATH <i>Aug 27 1967</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 1, 1881</i>		9. AGE (In years last birthday) <i>85 yrs.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (County & State, or foreign country) <i>O'Brien Co Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>L.N.B. La Rue</i>					14. MOTHER'S MAIDEN NAME <i>Julia Deen</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <i>449-56-5582</i>		17. INFORMANT <i>Mrs. Helen L. Hazelton</i> Address <i>1302 66th, Montgomery, W. Va.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 4: DUE TO (b) <i>associated with Anemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>and hypothyroidism</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Senility</i>										
19. INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1966</i> to <i>Aug 27 1967</i> that (I) (we) last saw the deceased alive on <i>Aug 7, 1967</i> and that death occurred at <i>8 A</i> M, from the causes and on the date stated above.										
22a. SIGNATURE <i>Philip E. Jones</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>8/27/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Philip E. Jones MD</i>					22d. ADDRESS <i>800 Springdale Road Silver Spring Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>8/31/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>George Washington</i>			23d. LOCATION (City, town or county) (State) <i>Prosser Rd Md.</i>		
24. FUNERAL DIRECTOR <i>W W Chambers, Inc</i>					ADDRESS <i>8655 Gr Ave Silver Spring Md.</i>		25a. REC'D BY REGISTRAR <i>AUG 31 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

11229

CERTIFICATE OF DEATH

21230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <u>Silver Spring - Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>531 Brent Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET Kathleen LAVIN</u>				4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 27, 1967</u>	9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>		IF UNDER 24 HRS Hours <u>3</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Anthony Lavin</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET Catherine Tyrrell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Father</u>		Address <u>as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyaline Membrane Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-27</u> , 19 <u>67</u> , to <u>8-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-30</u> , 19 <u>67</u> , and that death occurred at <u>5:45</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Raymond Gibbons</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-31-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond Gibbons, M.D.</u>				22d. ADDRESS <u>2401 Blueridge Ave., Wheaton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>September 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>James T. Ryan</u>		ADDRESS <u>317 Pa. Ave. S.E.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	



CERTIFICATE OF DEATH

11231

11230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b COUNTY <u>Mont. Co.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN lb <u>7 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>8511-Lynbrook Dr.</u>	
3 NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>Lehrer</u> Middle Last		4 DATE OF DEATH <u>Aug. 17</u> 19 <u>67</u> Month Day Year	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/84</u> 9 AGE (In years last b rthday) <u>82</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10b KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u>	
11 BIRTHPLACE (County & State or foreign country) <u>RUSSIA</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>ISAAC LEHRER</u>		14. MOTHER'S MAIDEN NAME <u>YETTA GROSSOARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>057-10-5530</u>	
17 INFORMANT <u>HELMAN FURNAL</u> Address <u>1537 Gr. Concourse Brook, N.Y.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thrombosis Basilar Artery</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis, Generalized</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>undetermined</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma, Head of Pancreas</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>June 15</u> , 19 <u>65</u> , to <u>Aug 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 17</u> , 19 <u>67</u> , and that death occurred at <u>8:16 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Stanley M. Brewer</u> M.D.		22b. DATE SIGNED <u>18 Aug 67</u>	
22c PHYSICIAN'S NAME (Type) <u>STANLEY BREWER, M. D.</u>		22d ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md.</u>	
23a B. RIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>8-20-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>MT. SUDAN CEM.</u>	23d LOCATION (City or Town) (County) (State) <u>BROOKLYN N.Y.</u>
24 FUNERAL DIRECTOR <u>Goldberg Funeral Home 4817 9th St. N.W.</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 22 1967</u>			

11231

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11232

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1306 Woodside Pkwy.</u>		d. STREET ADDRESS <u>1306 Woodside Pkwy.</u>	
3. NAME OF DECEASED (Type or print) <u>Leonard La Salle Leimbach Sr.</u>		4. DATE OF DEATH Month <u>8</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	9. AGE (in years last birthday) <u>43</u> yrs
11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. COUNTRY OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonard Leimbach</u>		14. MOTHER'S MAIDEN NAME <u>Grace Quigley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>Yes</u>	
17. INFORMANT <u>Mary J. Leimbach</u>		Address <u>1306 Woodside Parkway Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gunshot wound in head with extensive laceration of upper cervical spine.</u> DUE TO (b) <u>976x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>laceration of upper cervical spine.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased shot self in mouth with pistol</u>	
20c. TIME OF INJURY Month Day, Year <u>10:30 pm 8/3 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden A. Neap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN A. NEAP</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>Aug. 3, 1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 7, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>John B. Thomas</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>		DATE <u>AUG 8 1967</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11232

11233

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>Berwyn Heights</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Sanit Hospital</u>		d STREET ADDRESS <u>5809 Swarthmore Dr.</u>	
3 NAME OF DECEASED (Type or print) <u>Stanley William Levin</u>		4 DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct 27-24</u> 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years past birthday) <u>42</u> yrs.
11 BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Levin</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Forman</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes and U.S.</u>		16. SOCIAL SECURITY NO	
17 INFORMANT <u>Wife - Mrs. Jacqueline Levin</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease.</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>Aug. 7, 1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE THEREOF <u>8-9-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN</u>		23d. LOCATION (City or town) (County) (State) <u>FALLS CHURCH VA.</u>	
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY SONS - WASHINGTON</u>		25a. REC'D BY REGISTRAR <u>DE</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 11 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11233		11234	
1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN TB 79 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND VIRGINIA b. COUNTY STERLING c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 206 FIR COURT e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ROBERT First Middle Last NORMAN NORMEN LEWIS		4 DATE OF DEATH Month Day Year AUGUST 19 1967	
5 SEX MALE	6 COLOR OR RACE CAUC	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 15 MAY 1941
9 AGE (In years last birthday) 26 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILITARY	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Union Co. New Jersey	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME NORMAN LEWIS	
14 MOTHER'S MAIDEN NAME MARTIAN HOLLY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES	
16 SOCIAL SECURITY NO. 225-52-9712		17. INFORMANT SANDRA L. LEWIS, 206 FIR COURT, STERLING, VA.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKINS DISEASE DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 22 MAY 1967 , to 19 AUGUST 1967 , that (I) (we) last saw the deceased alive on 19 AUGUST 1967 , and that death occurred at 4:50A M, from causes and on the date stated above.	
22a. SIGNATURE LT. D. J. JOHNSON, MC, USN		22b. DATE SIGNED 19 AUGUST 1967	
22c. PHYSICIAN'S NAME (Type) LT. D. J. JOHNSON, MC, USN		22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION (City or town) (County) (State) ARLINGTON, ARLINGTON, VA.
24. FUNERAL DIRECTOR ARLINGTON FUNERAL HOME, 3901 N. FAIRFAX DR. ARLINGTON, VA.		25a. REC'D BY REGISTRAR DATE AUG 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



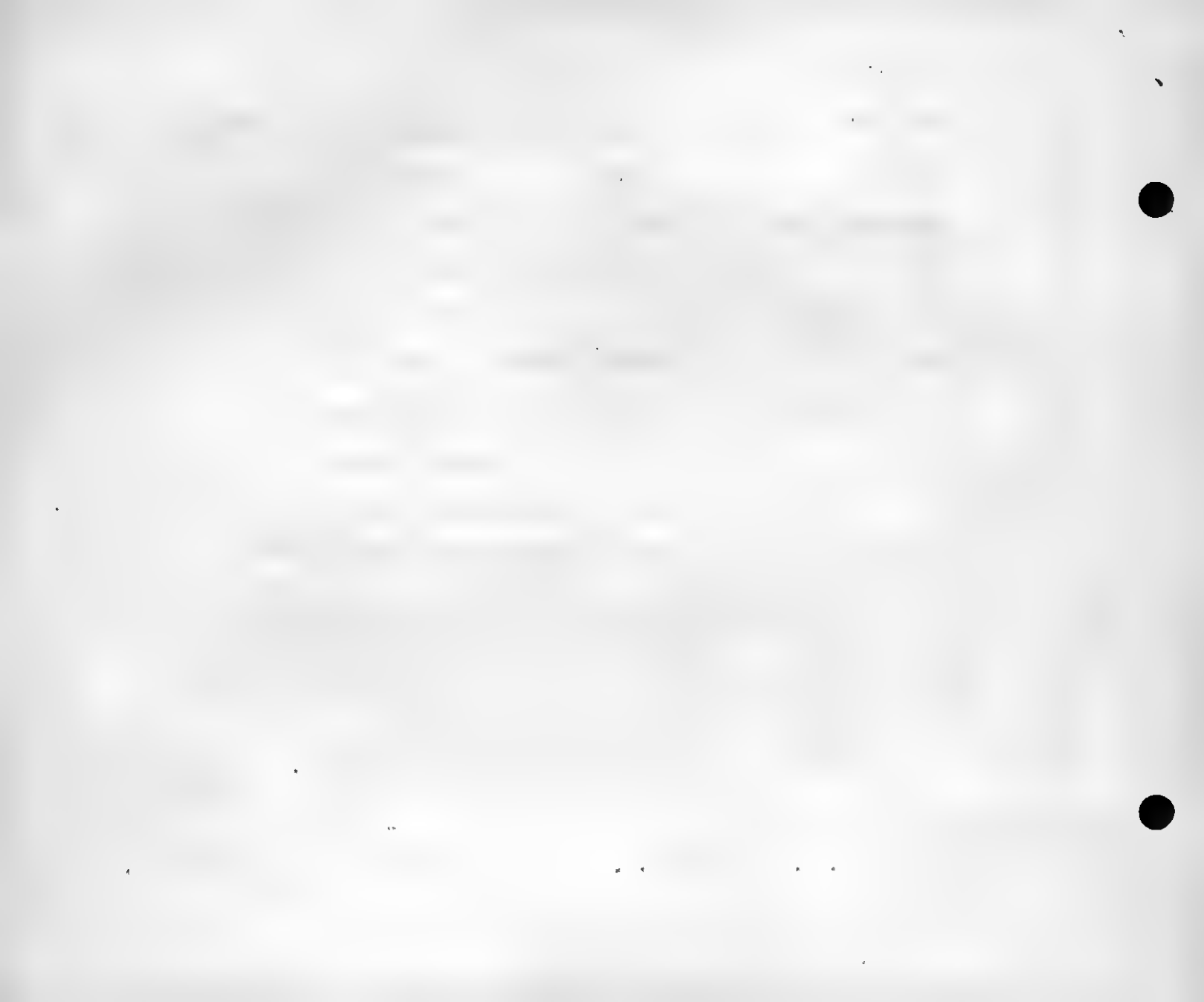
11234

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b DDA		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS English Manor 14007 London Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Thomas Joseph Loftus		4 DATE OF DEATH Month Day Year August 28, 19 67	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/03
9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR Months Days Hours Min. 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof Reader		10b. KIND OF BUSINESS OR INDUSTRY Gov't Printing Office	
11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick Loftus		14. MOTHER'S MAIDEN NAME Nellie Maher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO Medical Records	
17. INTERVALL BETWEEN ONSET AND DEATH 12 hrs.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January 19 60 , that (I) (we) last saw the deceased alive on 8/28 1967 , and that death occurred on 12:30 M , from causes and on the date stated above.			
22a. SIGNATURE A. D. Bonifant		22b. DATE SIGNED 8/28/67	
22c. PHYSICIAN'S NAME (Type) A. D. Bonifant, M.D.		22d. ADDRESS Medical Center, Sandy Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-1-67	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. RECD BY REGISTRAR DATE AUG 31 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



11235

CERTIFICATE OF DEATH

11236

1 PLACE OF DEATH a. COUNTY <u>Montgomery County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>1 1/2 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>University Nursing Home</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>S.E. (section)</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>S.E. (section)</u> d. STREET ADDRESS <u>11 46th St., SE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Flora Eva Lucas</u>		4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1885</u>
9. AGE (In years lost b rthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Char woman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Carolina Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Katherine ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Viola Green-11 46th St., SE, Wash., DC</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accro + Cva</u> DUE TO (b) <u>old age arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary heart failure</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> , 19 <u>67</u> , to <u>Aug 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 12</u> , 19 <u>67</u> , and that death occurred at <u>6:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Russell C. Bufalino</u>		22b. DATE SIGNED <u>Aug 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino, M.D.</u>		22d. ADDRESS <u>Silver Spring Md.</u> <u>1429 University Blvd., West,</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>	23d. LOCATION (City or Town) (County) (State) <u>4001 Suitland Rd. Suitland Md.</u>
24. FUNERAL DIRECTOR <u>Anderson T. Boyd</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 18 1967</u>	
The House of Boyd, 522 8th. St. S.E. Washington, D.C.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>1 1/2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3557 S. H. L. ...</u>					d. STREET ADDRESS <u>3557 S. H. L. ...</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>Callen</u> Last <u>L. P. C.</u>					4. DATE OF DEATH Month <u>Aug.</u> Day <u>6</u> Year <u>1967</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1901</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>W. Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry H. Lumbard</u>					14. MOTHER'S MAIDEN NAME <u>None</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Frank J. Lumbard Jr.</u> Address <u>Same as above</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Colon</u> DUE TO (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>8/6/67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>8/4/67</u> 19 <u> </u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>M. B. Queen</u>					22b. DATE SIGNED <u>8/6/67</u>			22c. PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>	
22d. ADDRESS <u>344 Univ. Blvd. W. Silver Spring Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Prince George's County Md</u>		
24. FUNERAL DIRECTOR <u>H. H. Hulseborn & Son</u>					ADDRESS <u>5732 Georgia Ave. N.W.</u>		25a. REC'D BY REGISTRAR <u>246</u> REGISTRAR'S SIGNATURE <u>[Signature]</u> DATE <u>AUG 10 1967</u>		

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1 67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11236

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18-21 Film G 391 8/21/67 cag

11238

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN IT <u>6 days</u>		2 USUAL RESIDENCE (Where deceased lived, if not last in residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Adelphi</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>2102 Quebec St</u>	
3 NAME OF DECEASED (Type or print) <u>Beth</u> First Middle Last <u>none</u> <u>Luxford</u>		4 DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <u>1</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>12</u> Hours <u>12</u> Min. <u>12</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Terry Mark Luxford</u>		14. MOTHER'S MAIDEN NAME <u>Carolyn Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Record, Washington San</u>		Address <u>Hosp</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>9/16/67</u> IMMEDIATE CAUSE (a) <u>Second and Third Degree Burns</u> DUE TO <u>of 80% of Body Surface</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased infant burned in fire in shed at home when gasoline lawn mower ignited.</u>	
20c. TIME OF INJURY Month Day, Year <u>5:10</u> <u>8/6/67</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u> <u>Adelphi, Pr. Geo. Co., Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Seap</u> EXAMINER'S NAME (Type) <u>BELDEN R. SEAP, M.D.</u>		22. DATE SIGNED <u>Aug. 13, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Aug. 14, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FT. Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor P.C., Md</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md</u>		25a. RECEIVED BY REG. STRAR <u>Aug 16 1967</u> DATE <u>Charles Judge</u>	
25b. REG. STRAR'S SIGNATURE			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3/Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

11238

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11239

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c LENGTH OF STAY IN 1b <u>13 yrs.</u>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE <u>MD.</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d STREET ADDRESS <u>12618 Dalewood Drive</u>		3 NAME OF DECEASED (Type or print) <u>WILLARD VAN BUREN LYNCH</u>		4 DATE OF DEATH Month <u>Aug.</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>Male</u>		6 COLOR OR RACE <u>Cauc.</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B DATE OF BIRTH <u>6-21-1920</u>		9 AGE (In years, months, and days) <u>47</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOP FOREMAN</u>		10b KIND OF BUSINESS <u>TRANSPORTIN</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>JOSHUA LYNCH</u>				14 MOTHER'S MAIDEN NAME <u>ETHEL LEE BISSIT</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16 SOCIAL SECURITY NO <u>577-18-2396</u>		17 INFORMANT <u>MADGE V. LYNCH (WIFE)</u>			
18 AB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gunshot wound through head</u> DUE TO (b) <u>apparently self-inflicted</u> DUE TO (c) <u>lost</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <u>Decapitated, depressed, shot self in head with pistol</u>					
20c TIME OF INJURY Month, Day, Year <u>5:30 PM 8-18-1967</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>8/18/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <u>Rockville, Maryland</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>8/23/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>	
24 FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>				ADDRESS <u>Rockville, Maryland</u>		25a REC'D BY REGISTRAR <u>AUG 21 1967</u>	
				25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11238

CERTIFICATE OF DEATH

2280

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>OHIO</u> b. COUNTY <u>HAMILTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CINCINNATI</u>	
c. LENGTH OF STAY in <u>3 Weeks</u>		d. STREET ADDRESS <u>1538 CLOVERHOLL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9216 CEDAR WAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>FRIEDA ELIZABETH MALLUVIUS</u>		4 DATE OF DEATH <u>August 12 1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MAY 21, 1902</u>
9 AGE (In years last birthday) <u>65</u> yrs		10 UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>BAVARIA GERMANY</u>		12 CITIZEN OF WHAT COUNTRY? <u>US</u>	
13 FATHER'S NAME <u>FREDERICK BAUER</u>		14 MOTHER'S MAIDEN NAME <u>Marguerity Bauer</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>274-48-3576</u>	
17 INFORMANT <u>URSULA DAVIDSON</u> Address <u>9216 Cedar Way</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA</u> DUE TO (c) <u>CARCINOMA OF STOMACH</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u> <u>3 HRS</u> <u>1 yr</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 30, 1967</u> to <u>Aug 12, 1967</u> , that (I) (we) lost saw the deceased alive on <u>Aug 12 1967</u> , and that death occurred at <u>11:55 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Madrice A. Sislew</u> M.D.		22b DATE SIGNED <u>Aug 13 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>MADRICE A SISLEW</u>		22d ADDRESS <u>916 19th St NW</u>	
23a BURIAL, CREMATION, REMOVAL (Type) <u>Cremation</u>	23b DATE THEREOF <u>8-14-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d LOCATION (City or Town) (County) (State) <u>Suitland Prince Geo Md</u>
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u> ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>AUG 21 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1
11240

11241

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, F institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>1</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>Silver Spring</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>		d STREET ADDRESS <u>1220 E.W. Highway</u>	
3 NAME OF DECEASED (Type or print) <u>IRVING MARKOWITZ</u>		4 DATE OF DEATH Month <u>AUG.</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 8, 1903</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Men's Furnishing</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Romania</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Herbert Markowitz</u>		14. MOTHER'S MAIDEN NAME <u>Pearl</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17. INFORMANT <u>Roye Markowitz - 1220 E.W. Highway</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GI Bleeding</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pancreatic Carcinoma & metastases</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 mos.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Hepatic encephalopathy</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>67</u> , to <u>Aug. 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug. 18</u> , 19 <u>67</u> , and that death occurred at <u>5 A.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Mari Schuler</u>		22b DATE SIGNED <u>8/19/67</u>	
22c PHYSICIAN'S NAME (Type) <u>MARVIN SCHNEIDER M.D.</u>		22d ADDRESS <u>911 Silver Sp Ave. S.S. MD 20910</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b DATE THEREOF <u>8/19/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Sharon Garden Cemt.</u>	23d LOCATION (City or Town) (County) (State) <u>Valhalla, N.Y.</u>
24. FUNERAL DIRECTOR <u>B. Dargatzis & Sons</u>		25a REC'D BY REGISTRAR <u>Wash. & C.</u>	
25b REGISTRAR'S SIGNATURE <u>James J. Jones</u>		DATE <u>AUG 21 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11241

11242

1 PLACE OF DEATH a COUNTY <u>Montgomery County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Silver Spring, Md.</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c LENGTH OF STAY IN 1b <u>3 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp</u>		d STREET ADDRESS <u>2416 - Evans Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>MARSHALL, Robert</u> LAST FIRST MIDDLE		4 DATE OF DEATH Month <u>Aug.</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/90</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Wash. Gas Light Co.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>JAMES MARSHALL</u>		14 MOTHER'S MAIDEN NAME <u>3Alder</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>DAISY M. MARSHALL - SAME AS ITEM 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>1621</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Advanced Bronchial Carcinoma</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 MONTHS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-31</u> , 1967, to <u>8-3</u> , 1967, that (I) (we) last saw the deceased alive on <u>8-2</u> 1967, and that death occurred at <u>5:30 AM</u> , from causes on and the date stated above.			
22a SIGNATURE <u>J. W. Peabody Jr.</u> M.D.		22b. DATE SIGNED <u>8.3.67</u>	
22c PHYSICIAN'S NAME (Type) <u>JOSEPH W. PEABODY JR</u>		22d ADDRESS <u>1234 19th St. N.W., Wash, D.C.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>Aug-5-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>SWITLAND MD</u>
24 FUNERAL DIRECTOR <u>Simmons Bros. 1661 - Good Hope Rd. SE</u>		25a REG'D BY REGISTRAR <u>WASH DC</u> DATE <u>AUG 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN ID <u>3 years 3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Belmont Nursing Home</u> <u>17220 New Hampshire Ave.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West Va.</u> b. COUNTY <u>unknown</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>unknown</u> d. STREET ADDRESS <u>unknown</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>MINNIE G Martin</u> First Middle Last					4. DATE OF DEATH <u>8 27 1967</u> Month Day Year				
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-1884</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luke Graham</u>					14. MOTHER'S MAIDEN NAME <u>Judy A. Moore</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-56-4107</u>		17. INFORMANT <u>Admission Record / B. Snow</u> Address <u>Belmont Nursing Home</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> 4000 DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>generalized arteriosclerosis</u> (c) <u>gradual generalized deterioration due to age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>70 years</u> years									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>12-16-65</u> , 19 <u>65</u> , to <u>8-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-31</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above.									
22a. SIGNATURE <u>John R. Spencer</u> <u>7-8-7-67-by John R. Spencer</u>					22b. DATE SIGNED <u>8-27-67</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <u>John R. Spencer</u>					22d. ADDRESS <u>BURTONSVILLE, M.D.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-31-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City, town or county) (State) <u>Leithurstburg Md.</u>			
24. FUNERAL DIRECTOR <u>Emmett C. Gardner</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>SEP 1 1967</u>				

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CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Uniontown</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>34 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014</u> <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>21 Pershing Court</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>(None)</u> Last <u>Matthews</u>		4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>25 January 1916</u>
9 AGE (In years lost birthday) <u>51</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Mary Belle Gross</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>1943</u>		16. SOCIAL SECURITY NO. <u>178-07-0527</u>	
17. INFORMANT <u>The Medical Record</u>		17. ADDRESS <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Septicemia with peritonitis</u> DUE TO (b) <u>Chronic glomerulonephritis</u> DUE TO (c) <u>Severe coronary arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis; lymphoma</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>28 July</u> , 19 <u>67</u> , to <u>31 August</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>31 August</u> 19 <u>67</u> , and that death occurred at <u>1:20</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Daniel Ein</u>		22b. DATE SIGNED M.D. <u>1 Sept. 1967</u> P.M. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Daniel Ein, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-2-67</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial</u>		23d. LOCATION (City or town) (County) (State) <u>Farmersville, Md.</u>	
24. FUNERAL DIRECTOR <u>Tracy J. F. 389 R. 4. Ave.</u>		25a. REC'D BY REGISTRAR <u>USEP 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Page</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

11244

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i> c. COUNTY <i>Prince Georges</i>	
c. LENGTH OF STAY IN 1b <i>4 months 8 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>Hyattsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>6902 24th Avenue</i>	
3 NAME OF DECEASED (Type or print) <i>Willard</i>		4. DATE OF DEATH Month <i>August</i> Day <i>1</i> Year <i>19 67</i>	
5 SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 8, 1918</i>
9 AGE (In years last birthday) <i>49</i> yrs.		IF UNDER 1 YEAR Months <i>1</i> Days <i>19</i> Hours <i>67</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dist. Freight Agent</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Southern Pacific</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John J. Mank</i>		14. MOTHER'S MAIDEN NAME <i>Maudie Parmley</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes</i> <i>WWII</i>		16. SOCIAL SECURITY NO. <i>422-16-7113</i>	
17 INFORMANT <i>Norma M. Mank</i>		Address <i>6902 24th Avenue Hyattsville, Maryland</i>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Malignant Melanoma</i> <i>1907</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>October 19 66</i> to <i>Aug 1, 19 67</i> that (I) (we) last saw the deceased alive on <i>Aug 1, 19 67</i> , and that death occurred at <i>10 PM</i> , from cause and on the date stated above.			
22a. SIGNATURE <i>Boris Rabkin</i>		22b. DATE SIGNED <i>August 2, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Boris Rabkin, M. D.</i>		22d. ADDRESS <i>1019 University Blvd. E., S. S., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE THEREOF <i>Aug 5, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Port Lincoln Cemetery</i>	23d LOCATION (City or Town) (County) (State) <i>Prince Georges Co., Maryland</i>
24. FUNERAL DIRECTOR <i>Glen Carter, Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>AUG 3 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Yunge</i>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-248

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not institution; Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>45 M.N.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Liburden</u>		d. STREET ADDRESS <u>6214 Kullerick Drive</u>	
3 NAME OF DECEASED (Type or print) <u>Harold James McDonnell</u>		4 DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 1 1895</u>
9 AGE (In years last birthday) <u>72</u> yrs		10 UNDER 1 YEAR Months Days Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Card operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hayward Calif</u>	
11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12 COUNTRY OF WHAT COUNTRY?	
13 FATHER'S NAME <u>James McDonnell</u>		14 MOTHER'S MAIDEN NAME <u>Ella Blankman</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16 SOCIAL SECURITY NO <u>700-05-5266</u>	
17 INFORMANT <u>Frances McDonnell</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - acute -</u> +201 DUE TO (b) <u>1 hr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>1 hr.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>8/6/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Burial - Transit</u>	<u>8/8/67</u>	<u>Burlingame, California</u>	<u>California</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>		25a. REC'D BY REGISTRAR <u>AUG 9 1967</u>	
Address <u>Rockville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11243

11847

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN <u>b</u> <u>D.C.A.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		d. STREET ADDRESS <u>14 Mills Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Kevin Robert McGowan</u>		4 DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 4 1957</u>
9 AGE (in years, lost birthdate) <u>10</u> yrs		10 UNDER 1 YEAR <input type="checkbox"/> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>	11 UNDER 24 HRS <input type="checkbox"/> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Pittsburgh, Pa.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph McGowan</u>		14 MOTHER'S M A DEN NAME <u>Shirley Schwartzmiller</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Joseph McGowan/father</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Injuries Severe</u> DUE TO (b) <u>being run over by Truck</u> CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (c) <u>Sudden</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>ran in path of Truck</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:10 p.m. 8/16 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc) <u>Highway</u>		20f. (City or town) (County) (State) <u>Gaithersburg Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>8/16/67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Mont. Co. Md.</u>	
24 FUNERAL DIRECTOR <u>GARTNER'S FUNERAL HOME</u>		ADDRESS <u>316 E. Diamond</u>	
25a. REC'D BY REGISTRAR <u>John G. Ball</u>		25b. REC'D BY REGISTRAR <u>John G. Ball</u>	
DATE <u>AUG 21 1967</u>			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11248

11249

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>years.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>6407 Stoneham Rd.</u>		e. STREET ADDRESS <u>6407 Stoneham Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>M</u> Last <u>MEYBOHN</u>		4 DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>Fe-</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec 1, 1908</u> 38 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Germany</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Gustav Anderson</u>		14 MOTHER'S MAIDEN NAME <u>Margaret Beckmann</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Son</u> <u>Richard L. Meybohm</u>		Address <u>Same as Item 2.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>Mucus Plugs, tracheo-bronchial tree</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO <u>Tracheo-bronchitis and early bronchopneumonia</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic mitral valvulitis, old with minimal mitral insufficiency</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
22 DATE SIGNED <u>Aug 17, 1967</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>8-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <u>Suitland, Maryland</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REG. STRAR DATE <u>AUG 23 1967</u>	25b. REG. STRAR'S SIGNATURE <u>Charles Judge</u>

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11243

2250

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>			
c. LENGTH OF STAY IN 1b <u>18 years</u>				d. STREET ADDRESS <u>3717 Dupont Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3717 Dupont Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>EDWARD</u> Last <u>MICHAEL</u>				4. DATE OF DEATH Month <u>AUG</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 4, 1909</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Presidential Hotel</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Castle, Ind.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Frank C. Michael</u>			
14. MOTHER'S MAIDEN NAME <u>Nina Brown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Yes</u>				17. INFORMANT <u>Heleen B. Michael</u> Address <u>Kensington, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Blood Glucose Imbalance</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1967</u> to <u>Aug 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 12, 1967</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert T. Thibadeau</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>				22d. ADDRESS <u>ROCKVILLE MD. 20852</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>August 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Switland, Maryland</u>							
24. FUNERAL DIRECTOR <u>John E. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>Aug 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

as directed to Dr. B. Keap

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical Certification

MONTGOMERY STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11250			
CERTIFICATE OF DEATH			
1-251			
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 6 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. STREET ADDRESS #717 Whitaker Terrace	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Aloysius Miller		4. DATE OF DEATH Month Day Year August 20 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-1896
9. AGE (in years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Sup't.-Registry Div., Post Off. Washington, D.C.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Miller		14. MOTHER'S MAIDEN NAME ? Mary A. Conway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes-in Army 2 days		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Miller (wife)		17. ADDRESS 1717 Whitaker Terrace Silver Spring, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-01 DUE TO (b) Coronary occlusion (c) Coronary arteriosclerotic Cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH about 10 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 68 to 20 Aug 67, that (I) (we) last saw the deceased alive on 14 July 1967, and that death occurred at 1:30 A.M. from causes on and on the date stated above.			
22a. SIGNATURE Thomas P. Fogarty		22b. DATE SIGNED 20 Aug 67	
22c. PHYSICIAN'S NAME (Type) THOMAS P. FOGARTY		22d. ADDRESS 1011 UNIVERSITY BLVD. E. S. S. MD	
23a. BURIAL, CREMATION, or other disposition BURIAL		23b. DATE THEREOF 8-23-67	
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.		23d. LOCATION (City or Town) (County) (State) SILVER SPRING, MARYLAND	
24. FUNERAL DIRECTOR Collins Funeral Home		25a. REC'D BY REGISTRAR DATE AUG 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

11252

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY ... c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8107 17th place d. STREET ADDRESS LANGLEY PARK		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JAMES CHARLES MILLER		4 DATE OF DEATH Month Aug Day 30 Year 1967			
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 22 1916	9 AGE (In years last birthday) 50 yrs.	10. IF UNDER 1 YEAR Months ... Days ... Hours ... Min. ...
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SWITCHTENDER		10b. KIND OF BUSINESS OR INDUSTRY Wash. Terminal		11 BIRTHPLACE (County & State or foreign country) Washington D.C.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John T. Miller		14. MOTHER'S MAIDEN NAME Mario Murphy	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 719-03-1717		17 INFORMANT MRS LUELLA MILLER - wife	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis; peptic ulcer					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)		(County)		(State)	
21 I certify that (I) (this hospital) attended the deceased from May 1958 to Aug 1967 , that (I) (was) saw the deceased alive on 4 Aug 1967 , and that death occurred at 11:40 PM , from causes ... and on the date stated above					
22a SIGNATURE Thomas P. Fogarty M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 31 Aug 67	
22c PHYSICIAN'S NAME (Type) Thomas P. Fogarty		22d ADDRESS 1011 Univ. Blvd. E. Silver Spring, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 9/2/67		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d LOCATION (City or Town) Wash., D.C.		(County)		(State)	
24. FUNERAL DIRECTOR Malley's Funeral Home Inc.		25a REC'D BY REGISTRAR SEP 5 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

Classed by Med Examiner
for Signature by Dr. Fogarty

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11252

11253

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. R. indicate before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>Apt. 432</u> <u>3601 Connecticut Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Lucille C. Mills</u>		4. DATE OF DEATH Month <u>8</u> - Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. CO. OR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-77</u>
9. AGE (In years, months, days, hours, minutes) <u>90</u> yrs		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>0</u> Minutes <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Les Calvin Lester</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>164-16-6630B</u>	
17. INFORMANT <u>Husband - Rodney C. Same</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Paralytic Ileus</u> DUE TO (c) <u>Fracture of Right H.P.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u> <u>24 hr.</u> <u>7 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) <u>Fall at home causing fracture of Rt hip</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:30 pm 8/11 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Washington D.C.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Indetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John S. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>Aug 18, 1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u>	23d. LOCATION (City or town) (County) (State) <u>BLADENSBURG, M.D.</u>
24. FUNERAL DIRECTOR <u>Jos. GAWLER'S SONS, 5130 WIS. AVE. NW, WASH., D.C.</u>		25a. REC'D BY REGISTRAR <u>AUG 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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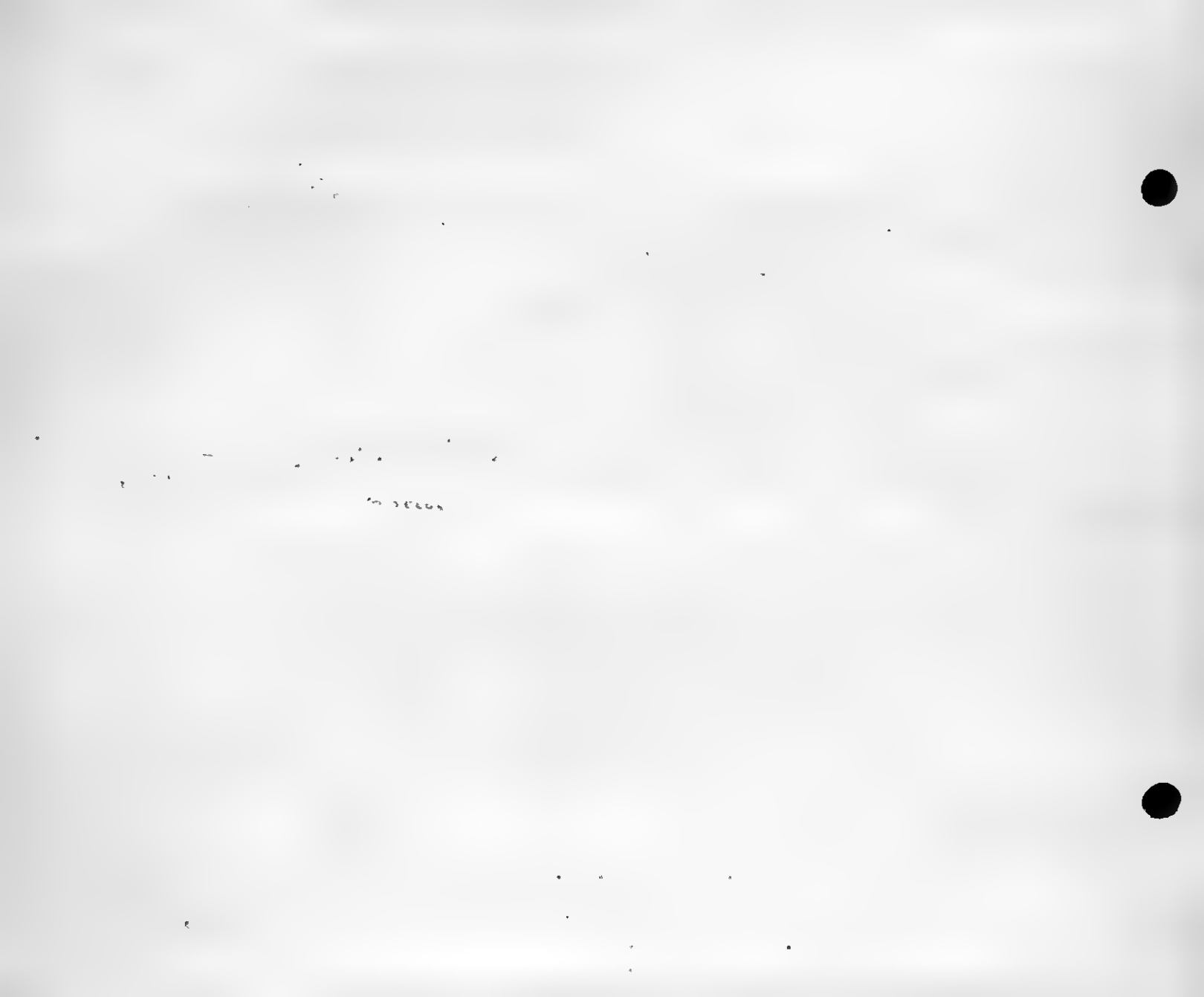
11253

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11254

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a. COUNTY <u>Montgomery.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia.</u> b. COUNTY <u>Washington.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda.</u>		c. LENGTH OF STAY in 1b <u>5 yr. 3 1/2 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington.</u>		d. STREET ADDRESS <u>4301 Mass. Avenue NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Restmor Sanatorium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Gizelle H. Montgomery.</u>				4 DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1967</u>			
5 SEX <u>Fe.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov 30, 1884</u>	9. AGE (In years last birthday) <u>82</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Louis Goodwillig</u>				14. MOTHER'S MAIDEN NAME <u>Regina Lowenstein.</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>none</u>		17 INFORMANT <u>Dr. Howard H. Montgomery-3326 Stuyvesant Pl.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia -</u> DUE TO (b) <u>Organic Brain Syndrome -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/5/67.</u>			
				Address (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>8/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, DC</u>	
24 FUNERAL DIRECTOR <u>The S.H. Hines Co.</u> ADDRESS <u>Washington, D. C.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>1</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>11254</div> <div>11255</div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, DC.</u> b. COUNTY <u>—</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>5 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>				d. STREET ADDRESS <u>1661 CRESCENT, N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Alpha Wood Land Nursing Home</u> <u>1400 Dale View Dr. Silver Spring, MD</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Irene</u>		First <u>MAEKLIN</u>		Middle <u>MORCY</u>		Last <u>—</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1882</u>		9. AGE (in years, last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Austin, Texas</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>August Palm</u>						14. MOTHER'S MAIDEN NAME <u>Adelia Belle Atwood</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs. Musgrave</u> Address <u>4640 Danfield St. N.W. Wash. D.C.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident.</u> DUE TO (b) <u>Natural causes.</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> NOT WHILE <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>—</u> , to <u>1967</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>5 May 67</u> 19 <u>—</u> , and that death occurred at <u>5:45</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>James W. Voellmann</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>14 Aug 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. W. VOELL M.D.</u>						22d. ADDRESS <u>1162 BRANTFORD AVE. S.S.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT. Cem.</u>				23d. LOCATION (City, town or county) (State) <u>ARLINGTON, VIRGINIA</u>			
24. FUNERAL DIRECTOR <u>Joseph Grawler's Sons Inc. Wash. D.C.</u>						25a. RECD BY REGISTRAR <u>AUG 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1.256

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MD Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS Route #1 Box 285	
3 NAME OF DECEASED (Type or print) George First Bruce Middle Burton Last MULLER		4. DATE OF DEATH Month 8 Day 7 Year 1967	
5 SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Dec 1920
9 AGE (In years lost birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Military		10b. KIND OF BUSINESS OR INDUSTRY USN	
11. BIRTHPLACE (County & State, or foreign country) Bristol, Va.		12. CITIZEN OF WHAT COUNTRY U.S.A	
13 FATHER'S NAME Frederick Muller		14. MOTHER'S MAIDEN NAME Bessie Jones	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 225-03-3795	
17. INFORMANT Juanita P. Muller Rt. #1, Box 285 Bethesda, Md.		Address Accokeek, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction, Acute DUE TO (b) Arteriosclerotic Coronary Vascular Disease, Severe DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour am 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3 August, 1967 to 7 August, 1967 , that (I) (we) last saw the deceased alive on 7 August 1967 , and that death occurred at 9:15 PM , from causes and on the date stated above.			
22a. SIGNATURE P. T. Kirchner		22b. DATE SIGNED 8 Aug., 1967	
22c. PHYSICIAN'S NAME (Type) P.T. KIRCHNER		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 11-1967	23c. NAME OF CEMETERY OR CREMATORY Arlington, National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Simons Funeral Home 1661 Good Hope Rd. S.E.		25a REC'D BY REGISTRAR DATE AUG 10 1967	
ADDRESS WDC		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 1 MONTH	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING (WHEATON)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAIRLAND NURSING HOME		d. STREET ADDRESS 11218 MONTICELLO AVE	
3. NAME OF DECEASED (Type or print) SARAH E MULLIN		4. DATE OF DEATH Month 8 Day 27 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1888
9. AGE (In years lost to birthday) 79 yrs		IF UNDER 1 YEAR Months 27 Days 27 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROVE BUYER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NATHAN MILES		14. MOTHER'S MAIDEN NAME JUDY ANN LARMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 220-54-0689	
17. INFORMANT Nursing Home Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolization 4221 DUE TO (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 5 yrs		INTERVAL BETWEEN ONSET AND DEATH APPROX ONE MINUTE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-27-67 , 19 8-27 , 1967, that (I) (we) last saw the deceased alive on 8-26 1967, and that death occurred at 8:30 AM , from causes and on the date stated above			
22a. SIGNATURE P. Coley		22b. DATE SIGNED 8/27/67	
22c. PHYSICIAN'S NAME (Type) P. Coley MD		22d. ADDRESS 3737 Legation St NW Washington D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Md.
24. FUNERAL DIRECTOR C. Glen Carter C. Glen Carter Warner E. Pumphrey Inc. 8434 Ga. Ave. S.S. Md.		25a. REC'D BY REGISTRAR AUG 29 1967	25b. REGISTRAR'S SIGNATURE William J. Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #2d Film #3492 8/24/67 pn											
11257											
CERTIFICATE OF DEATH											
11258											
1 PLACE OF DEATH a. COUNTY Montgomery						2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney						c. LENGTH OF STAY IN 1b 2 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital						e. STREET ADDRESS New Hampshire Ave., Belmont, Md.					
3 NAME OF DECEASED (Type or print) First Middle Last Mary nmn Murphy						4. DATE OF DEATH Month Day Year 8 18 19 67					
5. SEX female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/29/86		9. AGE (In years lost birthday) 81 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11 BIRTHPLACE (County & State or foreign country) Washington, D.C.				12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME August Neibel						14 MOTHER'S MAIDEN NAME Anna Aumet					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no NONE				16. SOCIAL SECURITY NO. 215-54-7491		17. INFORMANT Olney, Md. Address Medical Records of Montg. General Hospt.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) LOBAR PNEUMONIA											
DUE TO (b) PULMONARY EDEMA											
DUE TO (c) A.S.C. V.D.											
INTERVAL BETWEEN ONSET AND DEATH TERMINAL YES											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UREMIA - PYELONEPHRITIS - SEVERE - SATURILITY											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from 8/16, 1967, to 8/18, 1967, that (we) lost saw the deceased alive on 8/18, 1967, and that death occurred at 8:30 PM, from causes and on the date stated above.											
22a. SIGNATURE Donald R. Lewis						M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8/19/1967	
22c. PHYSICIAN'S NAME (Type) Donald R. Lewis, M.D.						22d. ADDRESS Sandy Spring, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/22/1967		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM. COLMAR MARLBOROUGH CO., MD.				23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR W.W. CHAMBERS, INC. - SILVER SPRING, MD.						25a. REC'D BY REGISTRAR DATE AUG 22 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...			



11259

CERTIFICATE OF DEATH

11259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Wash., D.C. b. COUNTY 47.2 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2526 South Dakota Ave., N.E. d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First McKinley Middle none Last Nicholson		4. DATE OF DEATH Month August Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/1901
9. AGE (in years lost birthday) 66 yrs		10. IF UNDER 1 YEAR Months 66 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Saluda, South Carolina	
11. BIRTHPLACE (County & State, or foreign country) Saluda, South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jim Hill		14. MOTHER'S MAIDEN NAME Lela	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 251-22-5710T	
17. INFORMANT John D. Nicholson, 2526 So. Dakota, Av., N.E.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cong. Heart failure. Pulm. Edema 4221 DUE TO ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic (c)		INTERVAL BETWEEN ONSET AND DEATH one day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic Carcinoma & Metastases		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 18 , 19 67 , to Aug 29 , 19 67 , that (I) (we) last saw the deceased alive on Aug 26 , 19 67 , and that death occurred at 8:00 M., from causes and on the date stated above.			
22a. SIGNATURE R. Bufalino, MD		22b. DATE SIGNED Aug 29, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Russell Bufalino		22d. ADDRESS 1429 University Blvd. West Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-2-1967	23c. NAME OF CEMETERY OR CREMATORY Family Plot	23d. LOCATION (City or Town) (County) (State) Saluda, South Carolina
24. FUNERAL DIRECTOR Luttrell's Funeral Home		25a. REC'D BY REGISTRAR AUG 31 1967	
ADDRESS 3831 La Grange Rd Wash. DC		25b. REGISTRAR'S SIGNATURE Charles Judge	



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11255

11280

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>10718 Tenbrook Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Mollie</u> First <u>None</u> Middle <u>Nicholson</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-96</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>70</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Jacob Lowenthal</u>		14. MOTHER'S MAIDEN NAME <u>Jenny Popolovich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Patient's Chart.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary artery disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>5 hrs</u> <u>20 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Generalized arteriosclerosis; diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/2</u> , 19 <u>66</u> , to <u>8/11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/11</u> , 19 <u>67</u> , and that death occurred at <u>6:50</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Donald W. Datlow</u> M.D.		22b. DATE SIGNED <u>8-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald W. Datlow, M.D.</u>		22d. ADDRESS <u>823 University Blvd, West Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>COMMUNITY CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>PLEASANTVILLE NEW JERSEY</u>
24. FUNERAL DIRECTOR <u>Goodman Funeral Home</u>		25a. REC'D BY REGISTRAR <u>AUG 15 1967</u>	
ADDRESS <u>+2179TH ST. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

11260

CERTIFICATE OF DEATH

11261

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Bethesda	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN Ib 4 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 706 D. MEMQ	
3. NAME OF DECEASED (Type or print) Kelli Lyn OAKLEY		4. DATE OF DEATH Month 8 Day 14 Year 1967	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Feb 1966
9. AGE (In years last birthday) yrs 1		IF UNDER 1 Year Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Na		10b. KIND OF BUSINESS OR INDUSTRY Na	
11. BIRTHPLACE (County & State, or foreign country) Patuxent River, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James S. Oakley		14. MOTHER'S MAIDEN NAME Mary E. Chapman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Na	
17. INFORMANT James S. Oakley		Address 706 D. Patuxent River, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hydrocephalus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am pm 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home form, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10 August , 19 67 , to 14 August , 19 67 , that (I) (we) last saw the deceased alive on 14 August , 19 67 , and that death occurred at 12:40 AM , from causes and on the date stated above			
22a. SIGNATURE T.E. Kelly		22b. DATE SIGNED 14 August 1967	
22c. PHYSICIAN'S NAME (Type) T.E. KELLY		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-16-67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR R.A. PUMPHREY		25a. REC'D BY REGISTRAR AUG 21 1967	
ADDRESS 7557 Wisconsin Ave. Bethesda, Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

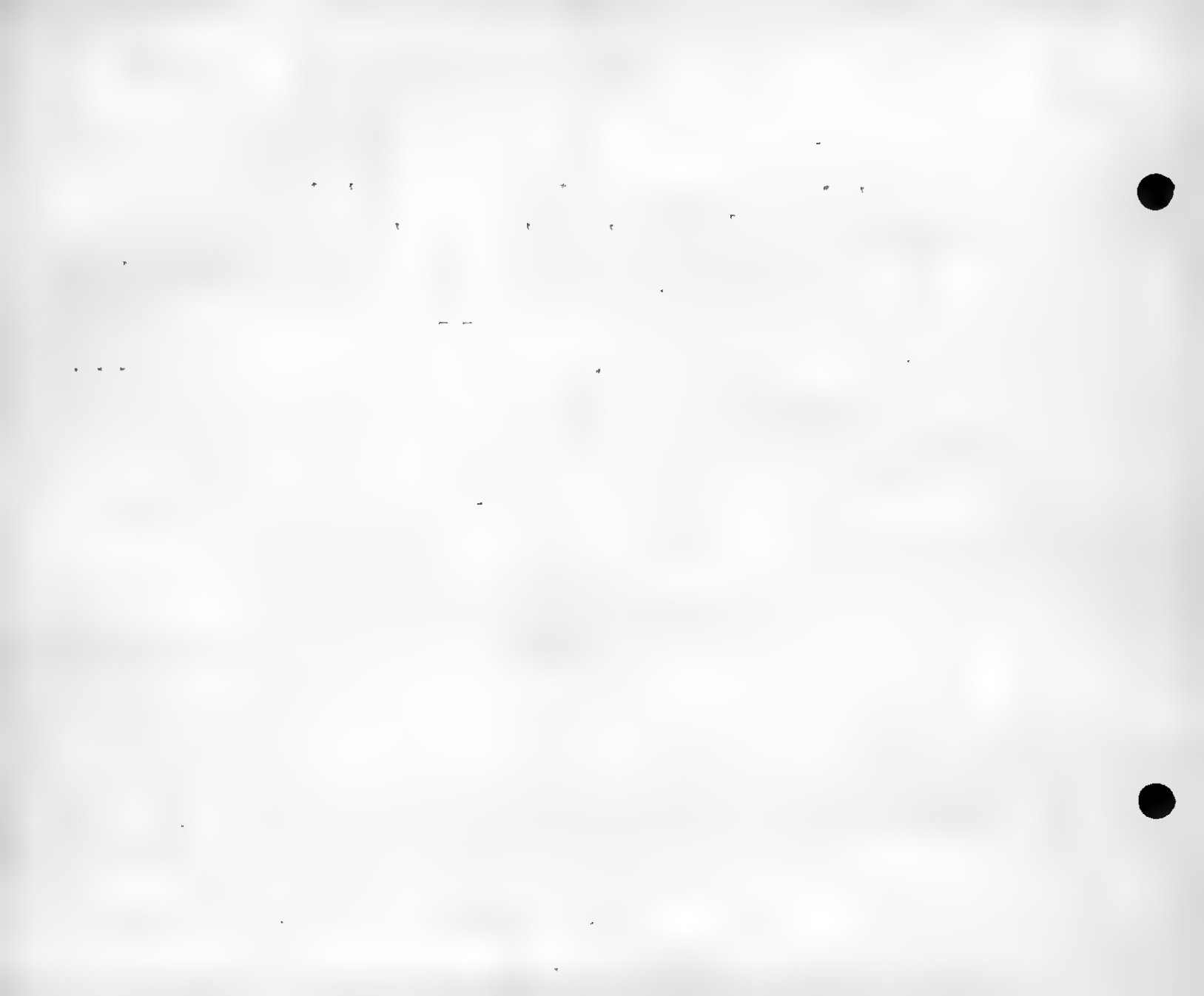
11261

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Md.		c. LENGTH OF STAY in 1b 45mins.		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Md.		d. STREET ADDRESS Box, 179		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) John Elias Offutt			4 DATE OF DEATH Month August Day 1 Year 19 67			5 SEX M		6 COLOR OR RACE C	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8 DATE OF BIRTH 4-1-12		9 AGE (In years last birthday) 55 yrs.		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Astro Comm. Lab	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Samuel Offutt		14 MOTHER'S MAIDEN NAME Elizabeth Randoff		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO.		17 INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Coronary Artery Heart Disease (c) Hyperthyroidism		INTERVAL BETWEEN ONSET AND DEATH		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .		22. DATE SIGNED August 2, 1967		23a. LOCATION (City or town) (County) (State) MT. ZION, MONTG. MD.		23b. REGISTRAR'S SIGNATURE Charles Judge	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/5/67		23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		23d. ADDRESS ROCKVILLE, MD.		23e. REC'D BY REGISTRAR AUG 7 1967	
23f. FUNERAL DIRECTOR Robert L. Szwed		23g. REGISTRAR'S SIGNATURE Charles Judge		23h. REGISTRAR'S SIGNATURE Charles Judge		23i. REGISTRAR'S SIGNATURE Charles Judge		23j. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

11262

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11263

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN lb <u>4 days</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Silver Spring</u>		d STREET ADDRESS <u>4416 Edgemoor Road</u>	
a NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Charles Edward Owens</u>		4 DATE OF DEATH <u>8 - 9 1967</u>	
5 SEX <u>M</u>	6 CO. OR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/21/33</u>
9 AGE (in years last birthday) <u>33</u> yrs		10 F UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Air Conditioning</u>	
11 BIRTH PLACE (State or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Gordon Owens</u>		14 MOTHER'S MAIDEN NAME <u>Helen U. Powell</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) If yes give war or dates of serv (es) <u>Yes Korean</u>		16 SOCIAL SECURITY NO <u>Yes</u>	
17 INFORMANT <u>Bertha Mae Owens</u>		Address <u>4416 Edgemoor Road Silver Spring, Maryland</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Skull with</u> DUE TO <u>Cerebral laceration incurred</u> in auto accident. (b) <u>in auto accident.</u> (c) <u>in auto accident.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased, driver, in auto which struck parked truck</u>	
20c TIME OF INJURY Month, Day Year <u>8-5 1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> at work or work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Street</u>		20f (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>MD.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>August 9, 1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Aug 12, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Prince Georges Co., Md.</u>
24 FUNERAL DIRECTOR <u>Clark E. Whitcomb</u> ADDRESS <u>8434 Georgia Avenue</u>		25a REC'D BY REG. STRAR <u>Charles Judge</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 17 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11263

CERTIFICATE OF DEATH

11264

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS SANITARIUM</u>		d. STREET ADDRESS <u>2115 P. St., N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>BERTHA R. PARKER</u>		4. DATE OF DEATH <u>Aug 11 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 25 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MONTANA</u>	
13. FATHER'S NAME <u>William C. Rawolle</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE ARMSTRONG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT (Nephew) <u>Rawolle Lochridge</u>		Address <u>1316 N.H. Ave., N.W. Wash., D.C.</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bencho pneumonia</u> DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 2, 1967</u> to <u>Aug 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 3, 1967</u> , and that death occurred at <u>9:55</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Robert T. Thibadeau</u>		22b. DATE SIGNED <u>Aug 11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		22d. ADDRESS <u>ROCKVILLE MD 20852</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>AUG 17 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

11264

11265

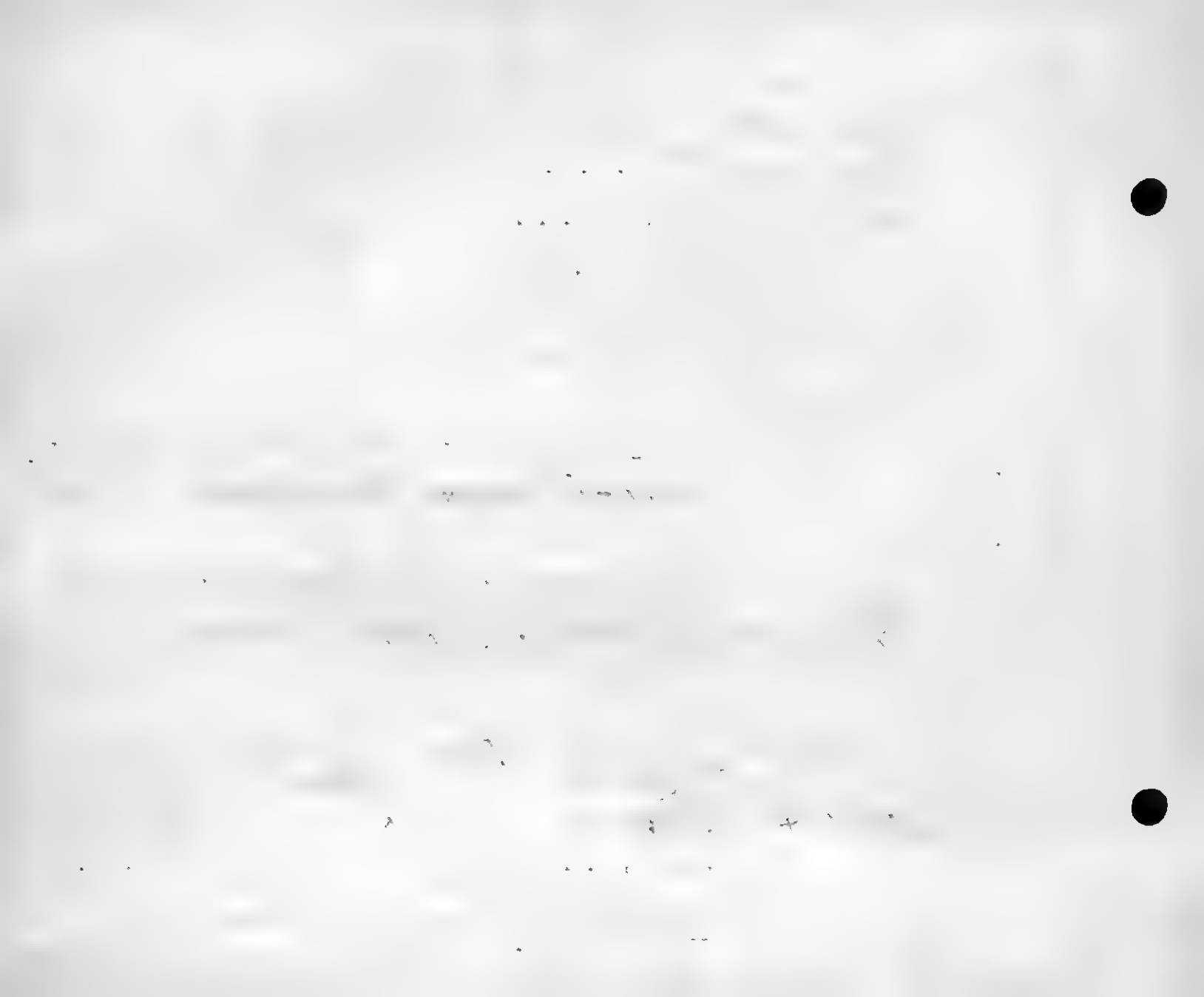
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared for Release by Dr. Reap, Medical Examiner

1 PLACE OF DEATH a. COUNTY MONTGOMERY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL D.O.A.		d. STREET ADDRESS 2501 NORBECK ROAD	
3 NAME OF DECEASED (Type or print) ORES Eugene PARKER		4 DATE OF DEATH AUGUST 15 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-97
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY PLASTERER	
11 BIRTHPLACE (County & State or foreign country) TEXAS		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM PARKER		14. MOTHER'S MAIDEN NAME 6---- BOYD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO None		16. SOCIAL SECURITY NO. 306-12-46269	
17. INFORMANT Mrs. Dorothy Parker Address 2501 Norbeck Rd. Silver Spring, Md.		FAMILY	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) INTERA-PULMONARY HEMORRHAGE DUE TO (b) CARCINOMA LUNG-ANAPLASTIC DUE TO (c) 8 Mo.		INTERVAL BETWEEN DEATHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA PROSTATE & BLADDER METASTASIS		19 WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from FEB , 1967, to 8/15 , 1967, that (I) (we) last saw the deceased alive on JULY 2 1967 , and that death occurred at 8:54 AM from causes and on the date stated above.			
22a. SIGNATURE Donald R. Lewis		22b. DATE SIGNED 8/15/67	
22c. PHYSICIAN'S NAME (Type) DONALD R. LEWIS, M.D.		22d. ADDRESS MEDICAL CENTER-SANDY SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR Glen Carter Warner E. Humphrey Funeral Home Silver Spring, Md.		25a. REC'D BY REGISTRAR Aug 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



11265

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner notified and approved - H. D. Ecker MD

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE MARYLAND COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEY CHASE		c. LENGTH OF STAY IN 1b 26 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4 EAST LENOX		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) THORNTON JENKINS PARKER JR		4. DATE OF DEATH Month August 11 Day 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 2 1899 68 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECH. ENGINEER		11. BIRTHPLACE (County & State, or foreign country) DISTRICT OF COLUMBIA	
13. FATHER'S NAME THORNTON J. PARKER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) USNR 1941-45		16. SOCIAL SECURITY NO. 577-40-7227A	
17. INFORMANT MARGARET PARKER (wife)		Address 4 E. LENOX CH. CH. MD.	
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 451X RUPTURED ABDOMINAL AORTIC ANEURYSM		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY 29 , 1967, to AUG 11 , 1967, that (I) (we) last saw the deceased alive on JULY 29 , 1967, and that death occurred at 1:58AM , from causes and on the date stated above			
22a. SIGNATURE H. D. Ecker		22b. DATE SIGNED 8/11/67	
22c. PHYSICIAN'S NAME (Type) HENRY D. ECKER		22d. ADDRESS 916-1916 ST. N.W., D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8/12/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. Wash., D.C.		25a. REC'D BY REGISTRAR AUG 17 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

11507

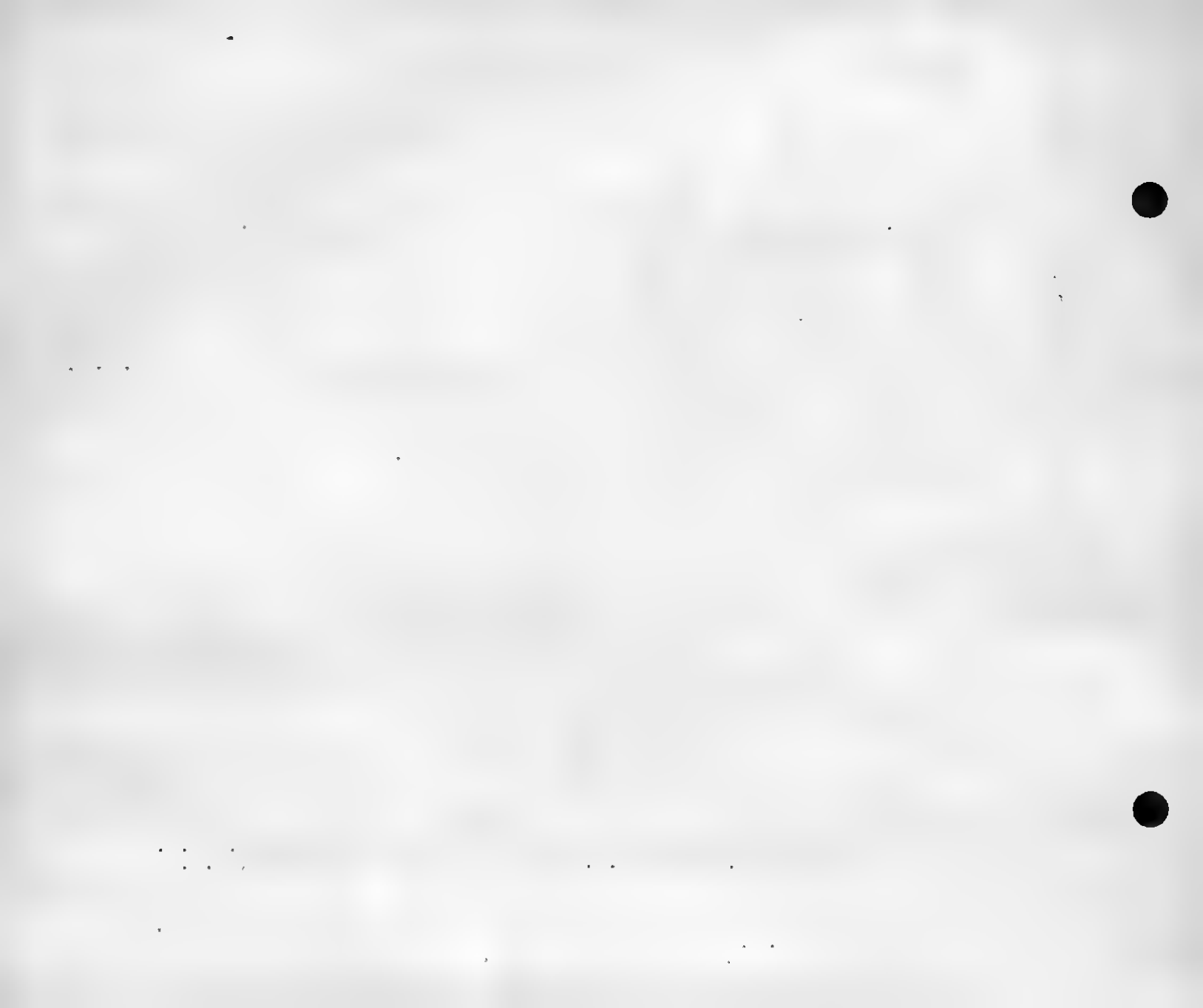
11266

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 2209 Quinton Rd.	
3. NAME OF DECEASED (Type or print) E. H. PAYNE		4. DATE OF DEATH Month August Day 1 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/81
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired decorator		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Charles Payne		15. MOTHER'S MAIDEN NAME Laura Hill	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. SOCIAL SECURITY NO 220-54-0190	
18. INFORMANT Laura P. Biggs same as #2		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforation of Cecum DUE TO Obstructing Carcinoma of sigmoid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/31 , 19 67 , to 8/1 , 19 67 , that (I) (we) last saw the deceased alive on 7/31 , 19 67 , and that death occurred at 9:30 AM , from causes and on the date stated above			
22a. SIGNATURE James T. Estes M.D.		22b. DATE SIGNED 8/1/67	
22c. PHYSICIAN'S NAME (Type) James T. Estes, M.D.		22d. ADDRESS 915 19th St., N.W. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 8/1/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland, Md.	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR The S.H. Hines Company		25. REC'D BY REGISTRAR AUG 2 1967	
25a. ADDRESS 2901 14th St. N.W. Washington, D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
c. LENGTH OF STAY IN 1b <u>7 days</u>		d. STREET ADDRESS <u>4330 Hartwick Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Edith H. Pearce</u>		4. DATE OF DEATH <u>8</u> Month <u>1</u> Day <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-27-97</u>
9 AGE (In years lost birthday) <u>70</u> yrs		IF UNDER 1 YEAR F UNDER 24 HRS Months Days Hours Min	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William Underwood</u>		14 MOTHER'S MARRIAGE NAME <u>Caroline Medley</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16 SOCIAL SECURITY NO. <u>218 160144A</u>	
17 INFORMANT <u>Virginia Pearce Updegraff</u>		Address <u>4651 Rustford Road, College Park, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>			
DUE TO (b) <u>Injuries, multiple, severe due to auto accident</u>			
DUE TO (c) <u>7 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18) <u>Passenger in car that ran off highway -</u>	
20c. TIME OF INJURY Month, Day, Year <u>9:15 am 7/26 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, factory, street, office, bldg, etc) <u>Highway</u>		20f. (City or town) (County) (State) <u>Near Germantown Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion a death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>Aug 2, 1967</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-4-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		23d. LOCATION (City or town) (County) (State) <u>BLADENSBURG, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO</u>		ADDRESS <u>RIVERDALE, MD</u>	
25a. RECD BY REG STRAR <u>DATE AUG 4 1967</u>		25b. REG STRAR'S SIGNATURE <u>Charles J. J...</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>1 day</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hospital</u>		d STREET ADDRESS <u>2022 Woodberry St.</u>	
3 NAME OF DECEASED (Type or print) <u>Hampton Lee</u>		4 DATE OF DEATH <u>8 - 17</u> 19 <u>67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (in years last birthday) <u>59</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Frank Peed</u>		14 MOTHER'S M maiden NAME <u>Hattie Sanders</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>577-58-8766</u>	
17 INFORMANT <u>Wife (Mrs. Sophie E. Peed (above)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Artery Heart Disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Arrhythmia (Type?)</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Peep</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. PEED M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>8/17/1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>8/21/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a REC'D BY REGISTRAR <u>AUG 22 1967</u>	
ADDRESS <u>Mt. Rainier Md.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11269

Item #9811m 73301 8/1/67

CERTIFICATE OF DEATH

11269

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 2924 Red Lion Lane	
3. NAME OF DECEASED (Type or print) Baby Girl Peterson		4. DATE OF DEATH Month August Day 6 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs 1 Mo 28
11. BIRTHPLACE (County & State, or foreign country) Takoma Park, Mont. Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dewey Edward Peterson		14. MOTHER'S MAIDEN NAME Barbara Page Minson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT Father		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory & respiratory failure DUE TO (b) Congenital anomalies - Encephalitis - Spina bifida DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Wallace McCune		22b. DATE SIGNED 8/7/67	
22c. PHYSICIAN'S NAME (Type) Wallace McCune, M.D.		22d. ADDRESS 911 Silver Spring Ave. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 8-7-67	23c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium	23d. LOCATION (City or Town) (County) (State) Takoma Park Mont. Md.
24. FUNERAL DIRECTOR J. Ruffcorn, 7600 Carroll Ave. Takoma Park		25a. REC'D BY REGISTRAR DATE AUG 11 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

CERTIFICATE OF DEATH

11270

3-2-71

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 4 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Asbury Methodist Home for the Aged, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Gilbert Phelps		4. DATE OF DEATH Month August Day 7 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1883
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months 7 Days 10 Hours 45 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Creswell, Harford Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Jason Gilbert		14. MOTHER'S MAIDEN NAME Anna S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT Asbury Methodist Home, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY 4200 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Dis. DUE TO (b) Generalized arteriosclerosis DUE TO (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (thus hospital) attended the deceased from 7/63 , 19, to 8/7/67 , 19, that (I) (we) last saw the deceased alive on 8/1/67 , 19, and that death occurred at 8:10 AM , from causes and on the date stated above.			
22a. SIGNATURE Henry C. Seruggs MD		22b. DATE SIGNED 8/7/67	
22c. PHYSICIAN'S NAME (Type) Henry C. Seruggs MD		22d. ADDRESS 5413 Cedar Lane Bethesda Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/9/67	23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cemetery	23d. LOCATION (City or town) (County) (State) Harford Co., Md.
24. FUNERAL DIRECTOR Wm J. Fishburne		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 8 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11271			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN TB 21 hrs 12 min	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Edward Last PHILLIPS		4. DATE OF DEATH Month August Day 21 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1967
9. AGE (n years last birthday) 21 yrs		10. IF UNDER 1 YEAR Months 21 Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ronald L. Phillips		14. MOTHER'S MAIDEN NAME Karen Gunter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO N/A	
17. INFORMANT Ronald L. Phillips, 7465-B 80th Ave.,		Address Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: Prematurity IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 20, 1967 , to Aug. 21, 1967 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Aug. 21, 1967 , and that death occurred at 1202 P , from causes and on the date stated above			
22a. SIGNATURE Frank X. Loeb		22b. DATE SIGNED Aug. 22, 1967	
22c. PHYSICIAN'S NAME (Type) Frank X. Loeb, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-24-67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR	
ADDRESS Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE AUG 25 1967			

267326

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11272

1-5-73

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R. Laytonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>on Griffith Rd.</u>		d. STREET ADDRESS <u>114 Frederick Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Rachel Beatrice Polk</u>		4. DATE OF DEATH <u>8</u> - <u>5</u> - <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Widowed</u>	8. DATE OF BIRTH <u>9-14-23</u>
9. AGE (In years, last birthday) <u>43</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Sampson</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-8274</u>	
17. INFORMANT <u>Hattie Jones, Seaford, Delaware</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head Injury Severe -</u> DUE TO (b) <u>Auto Accident -</u> DUE TO (c) <u>last</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Passenger in car Ran off Road</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:28 PM 8/5 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>High Way</u>	20f. (City or town), (County) (State) <u>R. Laytonsville Mont. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John W. Ball</u> M.D.		22. DATE SIGNED <u>8/5/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Chapel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Near Easton, Maryland</u>
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalburg, Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 18 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

11273

11273

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Jefferson</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tasoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> Wintersville, Ohio	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>109 Beechwood Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanitarium + Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>NORA, Belle Pontious</u>		4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3 1880</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Treasurer</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>W.C.U.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr Joseph Shaw</u>		14. MOTHER'S MAIDEN NAME <u>SARA Morrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>276-14-6488</u>	
17. INFORMANT <u>Mrs. Eugene A. Benson</u>		18. ADDRESS <u>1604 Neeley Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>stroke</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fatigue</u> <u>acute congestive heart</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-10</u> , 19 <u>67</u> , to <u>8-29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-28</u> , 19 <u>67</u> , and that death occurred at <u>12</u> P.M., from causes and on the date stated above			
22a. SIGNATURE <u>Veronica Troost</u> M.D.		22b. DATE SIGNED <u>8-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>VERONICA TROOST</u>		22d. ADDRESS <u>10236 N.H. Ave Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-Burial</u>	23b. DATE THEREOF <u>Sept. 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Napoleon Ohio</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumpkrey</u>		25a. REC'D BY REGISTRAR <u>SEP 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11274

11275

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>26 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>4801 Bradley Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lyman R. Porter</u>				4. DATE DEATH <u>Aug 3 1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/1891</u>		9. AGE (In years lost birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) <u>BURKSVILLE Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francis A. Porter</u>				14. MOTHER'S MAIDEN NAME <u>Laura Rangley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Wife Julia (Same as above)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> DUE TO (b) <u>Bronchiogenic carcinoma</u> DUE TO (c) <u>lost.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>July 1967</u> <u>1966</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>20 July, 1967</u> to <u>3 Aug 1967</u> , that (I) (we) lost saw the deceased alive on <u>3 Aug 1967</u> , and that death occurred at <u>12 PM</u> M, from causes on and on the date stated above.							
22a. SIGNATURE <u>Horace W. Bernton</u>				22b. DATE SIGNED <u>3 Aug '67</u>		22c. PHYSICIAN'S NAME (Type) <u>Horace W. Bernton, M.D.</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8-5-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bridgville Cem.</u>	
24. FUNERAL DIRECTOR <u>H. E. HARDESTY & SONS - BRIDGEVILLE</u>				25a. REC'D BY REGISTRAR <u>Charles J. J...</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	
26. DATE <u>AUG 7 1967</u>							



11275

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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(M)

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>60 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>3613 Chevy Chase Lake Dr.</u>	
3 NAME OF DECEASED (Type or print) <u>ELIZABETH POWELL</u>		4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/24/84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>	9. AGE (in years last birthday) <u>82 yrs</u>
11. BIRTHPLACE (County & State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W. S. Powell</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>213-10-9385A</u>	
17. INFORMANT <u>J. C. White</u>		Address: <u>Suburban Trust Company Bank</u> <u>Georgia Avenue, Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subsiding Embolism</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1950</u> , to <u>Aug 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 7, 1967</u> , and that death occurred at <u>10:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W.B. Wardrop MD</u>		22b. DATE SIGNED <u>Aug 8, 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.B. WARDROP MD</u>		22d. ADDRESS <u>808 Pershing Drive Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>Aug 12, 1967</u>	<u>Riverside Cemetery</u>	<u>Detiance, Ohio</u>
24. FUNERAL DIRECTOR <u>Glen Carter, 8434 Georgia Avenue, Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11276						11277					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nsg. Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47-3</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>2242 49th St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Frederick</u> Last <u>Preston</u>						4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-26-1883</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Forester</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Goumit</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Preston</u>						14. MOTHER'S MAIDEN NAME <u>Virginia Fulkerson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>577-48-0519</u>		17. INFORMANT <u>B. Greenley</u> Address <u>811 Houston Takoma Park, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> 331X DUE TO <u>Cerebro-Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> (c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (H) (this hospital) attended the deceased from <u>Nov 10, 1966</u> to <u>Aug 24, 1967</u> , that (H) (we) last saw the deceased alive on <u>Aug 24, 1967</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-24-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>						22d. ADDRESS <u>217 UNIV. BLVD., SILVER SPRING, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-26-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (city, town or county) (State) <u>Washington, D.C.</u>					
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>						25. REC'D BY REGISTRAR <u>Wisc. Ave. N.W. Wash. D.C.</u>		26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>AUG 28 1967</u>											

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11277

CERTIFICATE OF DEATH

11278

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN TB <u>48 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>				d. STREET ADDRESS <u>Rt. 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>August William Priebe</u>				4. DATE OF DEATH Month Day Year <u>8 11 19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/15/82</u>	
9. AGE (In years last birthday) <u>84 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Priebe</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Fibelkorn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-26-8831</u>		17. INFORMANT <u>Olney, Md.</u> Address <u>Medical Records of Montg. General Hospt.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>203x</u> DUE TO <u>UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYELOMA KIDNEY</u> (c) <u>MULTIPLE MYELOMA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>MONTH. 3-6 Mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>AUGUST 65 8/11</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>8/14/67</u> 19 <u>67</u> , and that death occurred at <u>10:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Donald F. Lewis</u>				22b. DATE SIGNED <u>8/12/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Donald Lewis</u>	
22d. ADDRESS <u>Sandy Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		23d. LOCATION (City or Town) (County) (State) <u>Sunshine Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>				25a. REC'D BY REGISTRAR <u>AUG 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Francis H. Barber</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Uterine
Myoma
Myoma

Wm. P. Smith

August 23 1904